IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOVAN D. DANIELS, )
Plaintiff, ) Civil Action
vs. ) No. 1:16-cv-00014
WEXFORD HEALTH SOURCES, INC.,)
et al., )
Defendants. )

The 30(b)(6) deposition of WEXFORD HEALTH SOURCES, INC., by ARTHUR FUNK, M.D., called for examination, taken pursuant to the Federal Rules of Civil Procedure of the United States District Courts pertaining to the taking of depositions, taken before KRISTIN C. BRAJKOVICH, a Certified Shorthand Reporter, CSR. No. 84-3810, of said state, via Zoom, on the 18th day of March, A.D. 2022, at 10:00 a.m.



PRESENT:

FOLEY & LARDNER LLP,
(321 North Clark Street, Suite 3000,
Chicago, Illinois 60654-5313,
1-312-832-4500), by:
MS. JASMINE REED,
jreed@foley.com, and
MS. ELVIA R. ANGUIANO,
eanguiano@foley.com,
appeared via zoom on behalf of
Plaintiff;

CASSIDAY SCHADE LLP,
(222 West Adams Street, Suite 2900,
Chicago, Illinois 60606,
1-312-641-3100), by:
MR. JOSEPH J. LOMBARDO,
jlombardo@cassiday.com,
appeared via Zoom on behalf of
Defendants.

REPORTED BY: KRISTIN C. BRAJKOVICH,
CSR No. 84-3810.



I N D E X



E X H I B I T S





MS. REED: Thank you. We are here for the 30(b)(6) deposition of -- give me one second -- Wexford.

ARTHUR FUNK, M.D.,
called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. REED:

Q. And, Dr. Funk, you have been designated by Wexford to be their corporate rep today; is that correct?

A. Yes.

Q. And have you been deposed before?

A. Yes.

Q. Okay. Well, I'm just going to go over three quick ground rules just to make sure that we are on the same page, but I'm not going to do my whole spiel for you. Is that okay?

A. That is fine with me.

Q. So the first one and most important one is, remember the court reporter, the lovely court reporter is taking down everything we say, so we just want to make sure that we don't talk over each other so it makes it easier for her. Are you okay

with that?
A. That's fine.
Q. Second one, make sure you understand my question. I'm back in the Midwest now. But I used to practice in Denver and California, so I would use weird Midwest words and they would just look at me like I was crazy. So this was generally my warning, like, if you don't understand a word I use or if I'm using a weird word, I probably have adopted some Colorado words over the years. Just go ahead and ask me to clarify, and I'll do it. Is that okay?
A. That is fine. And English isn't my first language, so I may use some odd words myself.
Q. Fair enough. The last one is, if you need a break, I'm happy to let you take one. The only thing that I ask of you is that you answer the last question that I posed before we take a break. Is that okay?
A. Sure.
Q. Okay. Now, there might be points in time where your counsel objects. You have been through this before. You know you still have to answer the question unless he instructs you not to?



A. I understand.
Q. Now, is there any reason why you feel like you cannot answer truthfully and accurately in this deposition today?
A. Yes.
MS. REED: Ms. Court Reporter, could you read back my question. I want to give Dr. Funk another chance to answer it.
(WHEREUPON, the record was read by the reporter.)
MR. LOMBARDO: So, Dr. Funk, you answered, yes, there was a reason you could not testify truthfully today.
THE WITNESS: No, that is not correct.
MR. LOMBARDO: Okay. Do you want to change your answer?
THE WITNESS: No. My answer is correct.
BY MS. REED:
Q. Let me ask a different question, try it a different way.
Dr. Funk, are you able to give your best and most accurate testimony today?
A. My best and most accurate, is what you asked?



Q. Yes.
A. To the best of my knowledge I would be able to do that, yes.
Q. Okay. And is there any reason that you can think of sitting here today that you would not be able to give your best testimony today?
A. No, not that I wouldn't at the time I was asked the question. I sometimes may remember facts later on. People refer to that as having their memory refreshed or being refreshed, so that occurs sometimes. So other than that, no, I would not know of any other reason.
Q. Okay. Fair enough. Just to give you some background, like I said, I practiced in Colorado, so this is essentially my veiled way of saying, Did you smoke weed this morning before this deposition? It's just a standard question to make sure that you are able to answer everything. Okay?
A. I understand. I'm just trying to answer your questions accurately.
Q. Yes. I appreciate that. Now, those are the ground rules.
Could you state and spell your name for the record?



A. Yes, Arthur Funk, A-r-t-h-u-r, F-u-n-k.
Q. And you had mentioned that you had been deposed before; is that correct?
A. Yes.
Q. And how many times?
A. Lots.
Q. Can you give me a rough estimate?
A. I would say between 400 and 500.
Q. Okay. And have you been a 30(b)(6) -- or strike that.
Have you been a corporate representative in a deposition for Wexford before?
A. Yes.
Q. And about how many times?
A. More than 200. Between 200 and 300, I would guess.
Q. And what about within the last year, have you acted as a corporate representative in a deposition for Wexford?
A. This calendar year or the last 12 months?
Q. The last 12 months.
A. Yes. Of course, yes.
Q. How many times within the last

12 months?
A. Again, I don't keep track, so I'm just guessing off the top of my head. Probably 30, 40, somewhere around there.
Q. Do you recall if any of those depositions involved a rheumatoid arthritis diagnosis?
A. Not that I recall. I don't think so, but perhaps. Again, there's been many, but I don't believe any were from -- about rheumatoid arthritis.
Q. Okay. About when did you find out that you would have to appear for this deposition today?
A. I didn't -- I was never told I had to appear. I volunteered to be the 30(b)(6) representative, and I don't remember when. It was some months ago, but I don't keep track of things like that. So it was months ago.
Q. All right. Now, you mentioned that you volunteered to be the 30(b)(6) representative. Are there other people in your office that you know of who act as corporate representatives in these types of cases?
A. Not in my office. In the corporation



there are, yes.
Q. Where is your office located?
A. In Chicago.
Q. And can you state your business address for the record?
A. No. I can be contacted through my attorney.
MR. LOMBARDO: Jasmine, I think we are going to make an objection just for security purposes. I think that Dr. Funk has a home office, so his home office and business office would be the same. And just because of Mr. Daniels' record, for security purposes we'll object to that.
He could give you Wexford's corporate office in Pittsburgh, but that is not where he is actually physically located, if you want that.
BY THE WITNESS:
A. I can certainly give you that address, if you would like.
BY MS. REED:
Q. I guess I just need you to confirm for the record -- and I note that your attorney did it, but I just need you to say it -- that your office is not the actual corporate headquarters. You have



a separate one?
A. That's correct, yes.
Q. Okay. Did you do anything to prepare for this deposition today?
A. Yes.
Q. Can you tell me -- can you describe generally what you did to prepare for this deposition?
A. Primarily, I reviewed records that Mr. Lombardo had provided to me and other documents related to the deposition.
Q. Did you conduct any searches on your own for documents related to this deposition?
A. No. I would have -- at the time the litigation was first filed, I would have participated in a litigation hold, it's called, from the company, where any documents relative to the complaint would have been forwarded to the risk management office, but I did not do that recently.
Q. And just to clarify, can you say with relative certainty that you did, in fact, participate in the litigation hold process for this case, or do you just typically participate in that?
A. That is my practice, and I believe I



did. I have no reason to believe I didn't.
Q. Okay. Other than reviewing records and documents, did you do anything else to prepare for the deposition?
A. I reviewed the standards of care for rheumatoid arthritis and some related disorders. That is all -- that is the only other thing I recall having done.
Q. Okay. Did you speak with anyone in preparation for the deposition?
A. Just counsel, Mr. Lombardo, and I would have communicated with the director of risk management at the corporate office, Mr. Joe Ebbitt, but that was just in regards to scheduling of the deposition.
Q. When you were preparing for the deposition, about how many times did you speak with, say via phone or video conference or in person, Mr. Lombardo?
A. I think it was three or four times, but the conversations would not have been restricted to this claim. It would have been any other claims that were pending that he was involved -- or we were both involved in.

Q. Okay. And of those three or four times, can you give me an estimate of the percentage of that time that was spent actually speaking about this deposition for this case?

A. It would have been the majority of the time, but I can't estimate what percent.

Q. Okay. And about how long did these conversations last?

A. Less than an hour, more than ten minutes. Between ten minutes and, I would say, 45 minutes, is what I would guess.

Q. Okay. I'm going to show you what will be marked as the first exhibit for this deposition. Okay. So how this works is, I'm going to type the exhibit number in the chat and then attach the document, just to make sure everyone has it.

Okay. So, Dr. Funk, can you see my screen now?

A. Yes, I can.

Q. And is that font size fine, or do I need to blow it up a little bit?

A. You'd need to blow it up for me to actually read the print.

Q. Okay. How is that?



A. That's a lot better.

Q. Okay. So I'm showing you what has been marked as Exhibit 1 for the deposition, and it's titled Second Amended Notice of Rule 30(b)(6) Remote Video Conference Deposition for Wexford Health Sources, Incorporated. Did I read that accurately?

A. Yes.

Q. I'm going to slowly scroll through this. So before today, had you seen this notice of deposition before?

A. Yes. It appears to be what I was provided by Mr. Lombardo.

Q. Okay. So now I'm going to go through each of the topics and ask you if you are prepared to testify about them today, so you know where I'm going with this.

We are starting on page 2 of Exhibit No. 1, Topic No. 1 reads, Policies related to medical treatment of prisoners at Illinois Department of Corrections.

Are you prepared to testify about Topic No. 1 today?

A. Yes.



Q. Okay. And how did you get prepared?

A. As I stated, by reviewing the information that was provided to me, my familiarity from my working in the department of corrections, and, specifically, for Wexford Health Sources.

Q. Okay. And I know it's repetitive, but I'm going to have to ask you the same question for every one. I understand that you'll say, As I just said. I'm just letting you know, I just have to make the record.

A. Sure.

Q. So Topic No. 2, Policies, procedures, and protocols for treatment of serious medical conditions, serious medical needs, or chronic medical conditions, including but not limited to, joint pain, arthritis, rheumatoid arthritis, elevated Rh factors, ulcers, abdominal pain, GERD, acid reflux, and gastritis.

Are you prepared to testify about Topic No. 2, as I just read it?

A. Yes.

Q. And how are you prepared to testify about it?

A. The same response as to No. 1.



Q. Okay. Topic No. 3, Policies, procedures, and protocols for screening inmates with serious medical conditions, serious medical needs, or chronic medical conditions including, but not limited to, joint pain, arthritis, rheumatoid arthritis, elevated Rh factors, ulcers, abdominal pain, GERD, acid reflux, and gastritis.

Are you prepared to testify concerning Topic No. 3, as I have just read it?

A. Yes.

Q. And how did you prepare yourself to testify on Topic No. 3?

A. The same response as Topic No. 1.

Q. Topic No. 4, Policies, procedures, and protocols for requesting outside medical tests and/or consultations with outside medical specialists.

Are you prepared to testify on Topic No. 4, as I just read it?

A. Yes.

Q. And how did you prepare to testify for Topic No. 4?

A. The same response as No. 1.

Q. Topic No. 5, Policies for participation

in grievance process at IDOC. Are you prepared to testify about Topic No. 5, as I just read it?

A. Yes.

Q. And how did you prepare yourself to testify about Topic No. 5?

A. Again. Same response as No. 1.

Q. Topic No. 6, Policies, procedures, and protocols for ordered medication not on the approved medication list. Are you prepared to testify about Topic No. 6, as I just read it?

A. Yes.

Q. And how did you prepare yourself to testify for Topic No. 6?

A. Again, same response as to No. 1.

Q. Okay. Topic No. 7, Policy to ensure that all medical services are provided in accordance with medically accepted community standards of care.

Are you prepared to testify about Topic No. 7, as I just read it?

A. Yes.

Q. And how did you prepare yourself to testify about Topic No. 7?

A. Again, same response as to No. 1.



Q. Topic No. 8, Point of contact for interaction between IDOC and Wexford. Are you prepared to testify about Topic No. 8, as I just read it?

A. Yes.

Q. And how did you prepare yourself to testify about Topic No. 8?

A. Same response as to No. 1.

Q. Okay. Topic No. 9, Policies, procedures, and protocols for Wexford's internal review of inmates' medical records.

Are you prepared to testify about Topic No. 9, as I just read it?

A. Yes.

Q. How did you prepare yourself to testify about Topic No. 9?

A. The same response as to No. 1.

Q. Topic No. 10, Intake, treatment, and screening of plaintiff. Are you prepared to testify about Topic No. 10, as I just read it?

A. Yes.

Q. And how did you prepare yourself to testify about Topic No. 10?

A. Same response as to No. 1.



Q. Okay. Topic No. 11, Wexford's correspondence and/or communications with Saleh Obaisi, M.D., and/or LaTonya Williams regarding the treatment of plaintiff.

Are you prepared to testify about Topic No. 11, as I just read it?

A. Yes.

Q. And how did you prepare yourself to testify about Topic No. 11?

A. Same response as to No. 1.

Q. Topic No. 12, Wexford's correspondence and/or communications with physicians and/or other health care professionals regarding the treatment of plaintiff.

Are you prepared to testify about Topic No. 12, as I just read it?

A. Yes.

Q. And how did you prepare yourself to testify about Topic No. 12?

A. Same response as to No. 1.

Q. Okay. Topic No. 13, Policies, procedures, and protocols related to the diagnosis and/or administration of prescription medications including, without limitation, any related to



inappropriately accelerated diseases.

Are you prepared to testify about Topic No. 13?

A. Yes.

Q. How did you prepare yourself to testify about Topic No. 13?

A. Same response as to No. 1.

Q. Topic No. 14, Policies, procedures, and protocols related to intake, medical treatment, and screening inmates for medical conditions at IDOC.

Are you prepared to testify about Topic No. 14, as I just read it?

A. Yes.

Q. And how did you prepare yourself to testify about Topic No. 14?

A. Same response as to No. 1.

Q. Okay. Topic No. 15, Policies, procedures, and protocols related to handling sick call records, medical call reports, incident reports, and monitoring of inmates.

Are you prepared to testify about Topic No. 15, as I just read it?

A. Yes.

Q. And how did you prepare yourself to

testify about Topic No. 15?

A. Same response as to No. 1.

Q. Topic No. 16, Policies and -- policies and related to the prescription and/or administration of prescription medication.

Are you prepared to testify about Topic No. 16, as I just read it?

A. Yes.

Q. Okay. And how did you prepare yourself to testify about Topic No. 16?

A. Same response as to No. 1.

Q. Okay. Topic No. 17, Wexford's document retention policies regarding documents that are relevant to this lawsuit.

Are you prepared to testify about Topic No. 17, as I just read it?

A. Yes.

Q. Okay. How did you prepare yourself to testify about Topic No. 17?

A. Same response as to No. 1.

Q. Okay. That is the end of the topics.

Now I'm going to dig a little further into your response to Topic No. 1 and how you prepared, as it applies to all of the topics.



Now, earlier when we talked about what you did to prepare, you said that you reviewed records and other documents; is that correct?

A. Yes.

Q. Okay. And you also said that you reviewed the standards of care of rheumatoid arthritis and other diseases?

A. For rheumatoid related diseases, is what I said, yes.

Q. Okay. Related. I apologize. Let's start with the records you reviewed.

First of all, what types of records did you review for this file?

A. The records that were provided by Mr. Lombardo.

Q. And what did those records consist of?

A. There were medical records. There were different legal correspondences and documents. I recall two grievances. There were some Wexford guidelines or policies. The deposition of the plaintiff and some utilization management records. That is what I recall, but there may have been some other documents. It's been some time since I reviewed them.



Q. That last thing, did you say utilization management records?

A. Yes.

Q. So my list consists of, for the documents that you remember reviewing, medical records, legal correspondence, grievances, Wexford guidelines, the deposition of plaintiff, and utilization management records. Is there anything else that you can think of?

A. I said legal correspondences or legal documents in the plural, not in the singular.

Q. Okay. Anything else?

A. Well, this deposition notice and some other documents, but, no, I don't recall anything else.

Q. The medical records that you reviewed, what institution did those medical records come from?

A. Several.

Q. Which ones?

A. Primarily, the Department of Corrections. A rheumatologist that was in Illinois but from his office somewhere in Central Illinois, and then just yesterday afternoon, I received some



records from Mr. Lombardo from the Cook County Health System for treatment of the plaintiff for four visits that he had there.

Q. Okay. Any other institutions that you can recall?

A. He may have had some testing at other facilities that I did not mention, but I don't know the name of them, as I'm sitting here right now.

Q. Do you have those documents with you?

A. No.

Q. How were those documents sent to you?

A. Via courier primarily. The records I received yesterday afternoon were scanned and sent electronically.

Q. Okay. Now, the legal correspondence, I don't want to get into communications between you and your attorney, so can you just generally describe what you meant by legal correspondences?

A. The different legal documents, such as the response to interrogatories, like this notice of deposition, the things like requests to admit, things like that.

Q. Okay. And by grievances, were you referring to the plaintiff's grievances that he

filed?
A. Yes. I believe there were two, yes.
Q. Now, let's discuss the Wexford guidelines that you reviewed. Was that one document, or was it multiple sets of guidelines?
A. There were portions taken out of guidelines that -- I believe there were more than one. I just scanned those. They were also just provided yesterday afternoon.
Q. Were those provided via e-mail?
A. Yes.
Q. All right. Do you recall the names of those guidelines?
A. Medical guidelines and medical policies and procedures, one or the other.
Q. Any other names or guidelines?
A. Not that I recall. I did not really have time because of the short notice to review them, but I have reviewed those -- all of Wexford's documents for other depositions, so I did not feel that I had a need to look at it specifically.
Q. Okay. And by deposition of the plaintiff, you mean the plaintiff in this case, correct?



A. Yes.
Q. Now, describe for me what utilization management records are.
A. They are records generated from Wexford's utilization management department regarding services that are primarily done outside of the facility, that is of the correctional facility where the plaintiff was housed.
Q. Can you give me an example?
A. They appear as screen shots, a computer screen shot with information written in it that pertains to Mr. Daniels, so it would have his identifying information and clinical information, such as what service or study was requested and then a summary of the conversation and justification for that service.
Q. Who fills out these or who creates or develops these records, the utilization management records?
A. The utilization management nurse in the corporate office in Pittsburgh.
Q. Okay. Now, let's switch to the standards of care for rheumatoid arthritis, the documents that you reviewed concerning that. Can



you describe for me what you reviewed to determine the standards of care for rheumatoid arthritis?
A. I reviewed documents that were published by a source called UpToDate. It's a medical reference that clinicians use.
Q. Is this an online resource?
A. Yes.
Q. Anything else?
A. No, that is what I recall.
Q. Okay. So the documents by UpToDate covered standards for rheumatoid arthritis and related diseases?
A. Yes. That is not all it contains, but it has those illnesses and many other illnesses.
Q. Okay. Did you speak with any of the employees involved in this lawsuit to prep for the deposition?
A. No.
Q. Okay. Other than your attorney and the risk management person, do you recall speaking with anyone else to prepare for this deposition?
A. No.
Q. Okay. You mentioned that you are familiar with Wexford's procedures based on your



own experience; is that accurate?
A. Yes.
Q. Okay. So now I'm just going to ask you some background questions, so I understand what your experience is. Is that okay?
A. Sure.
Q. Your current position is the regional medical director for Wexford; is that correct?
A. For Illinois.
Q. For Illinois. How long have you been in that position?
A. Since 2005.
Q. And what did you do before that, immediately before?
A. I was site medical director for a facility in Illinois, and I also -- for about six or eight months, as I remember, I performed utilization management functions for Wexford. That was in 2004 to 2005.
Q. Okay. So you were the regional -- or you are the regional medical director and you have been the regional medical director of Illinois since 2005, correct?
A. Yes.

Q. And prior to that, you were a site medical director?
A. Correct.
Q. And how long were you a site medical director?
A. Seven and a half years.
Q. And then concurrently with that position, you also had some utilization management duties from 2004 to 2005; is that correct?
A. Yes.
Q. When you were a site director, could you just generally describe for me what your duties were?
A. Clinical and administrative duties for the facility, and I supervised the clinical staff at the facility.
Q. And can you give me a little bit more detail about what it means to supervise the clinical staff at the facility?
A. Yes. I oversaw the services, the health care services that were delivered from all of the different departments at the facility, nursing, radiology, phlebotomy, dental, mental health, and then clinical. And then I was the direct



supervisor of the physicians, the staff physicians, that provided the direct care to the population.
Q. As a site medical director, were you involved with training of the physicians when they started?
A. Yes.
Q. Can you give me an overview of what the training entailed for a new physician at the site?
A. Yes. It consisted primarily of Wexford's orientation program and then some related documents that would have been applicable at the time of the orientation.
Q. What types of documents?
A. The provider handbook, policies from the State, different guidelines from the State, practices of the facility, the job description. And it would also include -- and it would depend on the individual candidate as to their experience, the clinical experience and whether they have correctional experience, but it would also include some mentoring that would either be done by me -- myself or with another physician.
Q. Okay. Let's switch to your utilization management duties. Could you just give me a brief



summary of what that entailed?
A. Wexford has a utilization management function called collegial review, where a physician reviews the requests by another physician. Those are requests for services outside of the facility. It is a teleconference meeting that consists of the physician who is making the request, a utilization management nurse, utilization management physician, in which case I was fulfilling that role, and the site scheduler. That is the person who schedules the request.

It consists at least of those four individuals, but sometimes others may join on the call, such as the health care unit administrator or director of nursing or somebody -- sometimes somebody from the administrative staff at the facility. And the call consists of the request, and then the review of the person's request, a discussion ensues and then a decision is made as to the best course of treatment consistent with the contract and the community standard of care.
Q. So is it fair to say that the purpose of those collegial reviews was to determine whether the patient should be referred outside of the



facility to another physician?
A. Whether it was appropriate, yes.
Q. And what were some reasons that during your tenure you would deny that request?
A. If it was not covered by the contract, not a service that we were to provide by the contract, or if it was not clinically consistent or reasonable or there was a better course of action.
Q. Can you give me a little bit more detail by what you mean by -- when you say something is not covered by the contract?
A. Yes, for each facility, Wexford has a contract to provide specific services, and it details and defines what services we are to provide, and then there are services that are not covered or not provided.

So the first would be to determine whether the service being requested was something that was under our contract to provide.
Q. Can you give me an example of something that would not be covered by the contract?
A. You are talking about Illinois?
Q. Yes.
A. Cosmetic procedures, organ transplant,

treatment of Hepatitis C and HIV, medication treatment I'm referring to, dialysis services at the time. That has since changed. It's now under our contract, but for most of the contract or the time period in question, it would have been dialysis services. Abortion services, sex change services, sex reassignment services, surgical sex reassignment.

Those are the ones that come to mind. Again, the contract defines what we do primarily, not what we don't do, but it does make reference to certain illnesses that I mentioned that are the Department of Corrections' responsibility.

Q. Okay. And so if something is not covered by the contract and you tell the physician from the site that it's not covered, then what is the next step for that physician?

A. He would need to resolve that. He would need to respond to that by telling the patient that the service is not provided and why it's not provided and then give them an avenue to whom -- to request that service.

Q. Okay. In your current role, are you still familiar with the utilization management



duties?

A. Yes.

Q. Okay. And as you have just described, the duties that you were doing from 2004 to 2005, has that collegial review process stayed the same throughout your tenure as the regional medical director?

A. Different individuals were involved, but recently the collegial review by -- my contract was eliminated with the last contract renewal, which was about nine months ago.

Q. Do you know why?

A. It was a request from the Department of Corrections.

Q. Okay. So prior to the elimination of the collegial review process, did that process stay the same as you have described it to me today?

A. Yes, approximately the same. There were tweaks with the policy that occurred over time, refining it and clarifying, but the procedure basically remained the same.

Q. Okay. Now, I'm going to pivot here to your regional medical director position. Can you generally describe for me your duties as the



regional medical director for Illinois?

A. Yes. I perform clinical and administrative duties as assigned to me by my supervisors.

Q. Who are your supervisors?

A. The clinical supervisor would be Dr. Stephen Ritz, and then my administrative supervisor would be Stacey Scott.

Q. What type of clinical duties does your supervisor assign to you?

A. To supervise the medical directors at the facilities that I'm assigned to and provide direct care, when called for, review care provided by other physicians. That may be the individuals that I'm supervising or other staff at the facility, but it would primarily be confined to the facilities that I oversee.

Q. Okay. And what are some of your administrative duties that are assigned to you from your supervisor?

A. Well, responding to legal matters would be one, such as this deposition. Related to that, other claims that come from inmates, attending meetings, reviewing data, information, things like



that.

Q. Okay. Do you have a separate medical practice outside from your role as a regional medical director for Illinois?

A. No.

Q. Okay. How long have you been employed by Wexford?

A. Since 1995, with the exception of about three years.

Q. Okay. Have you ever had a separate medical practice?

A. Yes.

Q. Okay. When did that end?

A. 1993 abouts.

Q. Okay. Just so I understand the hierarchy a little bit. Right now, when you supervise medical directors, are you supervising site medical directors, i.e., the prior position that you had?

A. Correct. That's correct.

Q. Are you involved with hiring at all?

A. Yes.

Q. Okay. And what are your duties related to hiring?

A. I interview prospective applicants. That is, either physicians or midlevel providers.
Q. And you --
A. Sorry. Just to clarify. Just for my region, not for the entire state.
Q. When you say "your region" but "not the entire state," which part of the state is your region?
A. The northern part. The state is divided into three for the regional medical director districts, so there's a northern, a central, and a southern. I'm the northern.
Q. So you are involved with interviewing physicians that work at the sites; is that accurate?
A. Yes.
Q. Okay. Is there a formal criteria or list that a physician has to meet in order to be employed at one of the sites?
A. There are requirements, yes.
Q. Okay. Are those requirements set forth in any document?
A. Yes.
Q. What document is that?



A. Well, in several documents, one of which would be the job description would define what services are -- what credentials are necessary. It's also defined in the contract of what credentials are necessary for each position.
Q. Now, when you refer to "the contract," is that the contract with that specific physician or the contract that you have with the Department of Corrections?
A. The contract that we have with the Department of Corrections and Health and Family Services.
Q. Okay. Once the physicians and other employees are hired, are you involved with training in your current role?
A. Yes.
Q. And what are your responsibilities related to training?
A. Orientation of the physician or sometimes midlevel provider, depending on the individual circumstance.
Q. Other than the orientation, is there any other type of training?
A. A mentoring process usually occurs,



where the physician will work alongside another physician, and then there's ongoing training that occurs as the need arises.
Q. How frequent is the ongoing training?
A. As the need arises, so like -- excuse me. Let me just get this.
(WHEREUPON, there was a short interruption.)
BY THE WITNESS:
A. I'm sorry. I said, As the need arises.
BY MS. REED:
Q. Okay. So in your experience, how typically does the need arise? Is it once a year, more than that?
A. So it may be daily in some cases, but then it may be several months. It depends on the time the person was hired. It could be more frequent or more -- it would be more relevant to occur shortly after the person was hired, and then if somebody has worked for several years, in some cases we have had physicians that have worked for over 30 years, there would be less interaction in that instance. But whenever there was a change of policy, there would be some discussion of that.



Q. Okay. Are the physicians reviewed on a regular basis?
A. Yes.
Q. Are you involved with the review of their performance?
A. Of the physicians that I supervise, yes.
Q. And what does that entail?
A. Reviewing their performance as it relates to their decisions that they make and their functioning in their role, in their position. That occurs on an ongoing basis.
Q. Do the physicians ever receive written feedback on their performance?
A. Yes.
Q. How often do they receive written feedback?
A. As called for. If there is a corrective action that is necessary, they would certainly receive correspondence, or in some cases if it's a positive review, positive finding after review, they may receive that or it may be done verbally. Generally, it's done verbally, but it may occur in writing. Then there are -- the corporation does annual reviews of its employees. That also takes

place.
Q. Okay. So is it fair to say the physicians that you supervise are reviewed on an annual basis and then as needed aside from that?
A. I would say the review occurs on an ongoing basis as they make decisions and I critique their decision-making process and their performance in their position, whenever I have interaction of that.
In addition, there's a review that occurs, an annual review that occurs, that I may participate in, but the review is on an ongoing basis. It would not be reasonable to have a deficiency unaddressed and reviewed at the end of the year. It has to be done at the time so that the review can be -- can be appropriate and any response could be done in a timely manner.
Q. Let me dig into that a little bit. So I'm trying to figure out, like, do you review every decision they make, or is it just like there's a certain level of decision that triggers your review? I'm just trying to get --
A. No, only those that I'm involved in. So I have nine facilities, there are nine medical



directors. They are making decisions continually. I obviously can't review all of those decisions.
Q. Right.
A. So it would only be those that came to my attention that I had involvement with.
Q. Okay. And I just want to clarify, so you review the site medical directors as well as the physicians that work under those directors?
A. I review specific aspects of their work for both the -- for the medical staff. That includes site medical directors and physicians. Some facilities don't have a physician in addition to a medical director, a few of them actually only do, but that would apply.
The direct supervisor of the physician would be the medical director, so they would actually be the supervisor that is responsible for the oversight of that person's performance. But I would also -- I'm an indirect supervisor of that individual as well, and if something came to my attention, I would review that event and the performance and the response of that person in that situation.
Q. Is there any type of situation that you



can think of that is always going to be escalated to you for review?
A. Not any specific matter, but anything of significance would be escalated to me. I mean, if there was a -- anything of significance. I can't think of a specific matter. I mean, there are certain diseases, like meningitis, for example, it's an uncommon serious disease. That would certainly be brought to my attention.
There are many other very significant, very rare illnesses that certainly would come to my attention, but I can't -- yeah, I can't really list all of them.
Q. Can you list a few of them, just so I get an idea of the types?
A. Well, meningitis. There is a syndrome called neuroleptic malignant syndrome. An illness that was unexpected and resulted in death. Serious infections, like Ebola type of infections. There's a disease called necrotizing fasciitis, which is a very serious illness. That would be brought to my attention. So those are the illnesses that would be brought to my attention, but other matters relating to the employee would be brought to my



attention. Illness or, you know, death or something like that has actually occurred with one of the plaintiffs here. Things like that obviously would be brought to my attention.
Q. So if a physician asked for an outside referral, which triggered the collegial review, would that be brought to your attention?
A. No.
Q. Okay.
A. Not in the current or in the recent. Obviously, it did when I was performing that function, and then when I took the position of regional medical director, one of our duties was to be the utilization management physician, do the collegial review for our facilities. That went on for about four or five years, as I remember, so that would have been 2005 to 2009 or '10.
Then it was assigned to another physician in the corporate office. It was removed from our responsibilities.
Q. You mentioned that you had a separate practice up until about 1993; is that correct?
A. Not a separate practice. I had a practice.

Q. Oh, you had a practice?
A. I did not have one in addition to working for Wexford, I think is what you asked, but I had my own medical practice, yes.
Q. And did you have a specialty?
A. Yes.
Q. What was your specialty?
A. Internal medicine.
Q. How long did you have that practice?
A. About eight years.
Q. Could you just generally recite your education, your degrees that you have?
A. M.D. degree, University of Illinois, and then after that, I did an internship and residency in internal medicine, so my degree is M.D.
Q. Okay. And what year did you attain your M.D.?
A. '82, 1982.
Q. Okay. And have you received or obtained any other certifications related to your practice?
A. Yes.
Q. What certifications?
A. CCHP and board certification in internal medicine.



Q. What does CCHP stand for?
A. Certified correctional health care provider.
Q. When did you receive that certification?
A. I don't recall the year. It would have been in the '90s, sometime in the late '90s, mid-'90s.
Q. Is that certification still active?
A. Yes.
Q. Okay. Do you have to participate in any continuing education to keep that certification active?
A. Yes.
Q. Okay. In your position as a regional medical director, how often are you onsite at a facility?
A. It varies. It's been different since the advent of COVID, where we have gone mostly to remote contact. So prior to COVID, most days. I would say four out of five days I would be at a site, three to four out of the week. Now, about once a week.
Q. Did you have a particular schedule for your site visits?



A. There were some meetings that I would attend, but few. Mostly it was on an as-needed basis.
Q. Okay. Are you familiar with the Stateville Correctional Center?
A. Yes.
Q. And have you been onsite at that correctional center?
A. Yes.
Q. Has that always been one of the facilities in your region?
A. Yes.
Q. And by "always," I mean since you became the regional director.
A. Correct.
Q. Okay. Now, of the physicians that work for the site medical directors, are physicians assigned to a particular facility or do they tend to rotate?
A. Generally, yes, they have a primary position. In some cases there is a sharing, and that would be limited in my region to Stateville and its neighboring facility, Stateville NRC. They are immediately adjacent, and they do share



providers because of the unique demands of those facilities.
Q. Okay. So have you observed physicians meeting with patients at your facilities?
A. Yes.
Q. And can you describe for me the procedures that they follow when meeting with the patient?
A. Yes. They would introduce themselves. They would have the patient seated. And then they would conduct an interview while the chart was present and determine the reason for the visit, and then ask appropriate questions, give the patient an opportunity to respond and to voice their concerns, their medical concerns.
Then they would conduct an examination and come to a decision for a plan of care, based upon their findings. That would be documented in the progress note of the chart. The patient would be advised as to what the physician's thought process was and what course of action was being undertaken, and if medications were prescribed, what they were, what the side effects were, and what they were to expect in terms of when to

receive the medication. And then subsequent care that would be provided, whether that was X-rays or blood tests or follow-up visits or a referral to somebody. So that is a rough overview of what occurs.

Q. Now, you mentioned they would conduct an interview of the patient and they had the chart with them during that interview; is that correct?

A. Yes.

Q. Okay. And was it standard practice for the physicians to review the patient's prior medical records or charts before seeing them?

A. As applicable to that visit. So that may entail a review of that volume or sometimes there's more volumes, or it may not. It depends on the complaint.

Q. Okay. So there were some complaints that would not require review of the prior medical records?

A. Some complaints and some situations. For example, a physician that had regularly seen a patient would have knowledge of that patient's past record and findings and wouldn't need to or they may just scan it to refresh their memory or review



their notes. But there are some conditions that -- where a review of the record would be very limited. So I would -- I'll correct myself. It's not that they wouldn't need to review it at all, but they would not need to review it in depth.

Q. What types of conditions, for example?

A. If a person had a rash that had never occurred before, there would be no need to look through the patient's entire record, but you would look at relevant things, such as their medications, their allergy history, their general medical conditions, if they have something called a problem list. It would just be a review of a limited portion of the record.

Q. Okay.

A. Or I'll give you another example. If somebody has a fracture, if they are playing basketball and they fracture their ankle, again, the review would be limited relevant to that visit. Even if they had another fracture, it's really not relevant to that visit. What is relevant is their current fracture, the state of the fracture and the degree and where the fracture is located. And all what would be relevant would be to know their



general health, their allergy history, other medical conditions that might impact on the treatment that might be necessary, such as surgery, things like that, but you would not go over their entire medical history for something like that.

Q. And if a patient presented with pain in various areas of their body, would that be something that would require a review of the medical records?

MR. LOMBARDO: I'm going to object to form, incomplete hypothetical. You can answer to the best of your ability, Doctor.

BY THE WITNESS:

A. Yes. Generally, if a patient had that complaint, it would depend on a number of factors, the specifics of when the -- am I being heard because I'm not being shown. Can you hear me?

BY MS. REED:

Q. I can hear you, yes.

A. Oh, okay. It would depend on the specifics of it, but, in general, yes, it would require -- it should require a review of the record as it pertains to that symptom and to look for other visits that may have been similar.



Q. Let's talk about the standards of care for rheumatoid arthritis. Now in your prior practice in internal medicine, did you have experience with rheumatoid arthritis?

A. Patients with rheumatoid arthritis?

Q. Yes.

A. Yes.

Q. Okay. Did you ever diagnose somebody with rheumatoid arthritis during your medical practice?

A. Yes.

Q. How often roughly did you have to deal with patients with rheumatoid arthritis?

A. Whenever it applied, whenever a patient had the illness. So whenever I was taking care of a patient and they had it, then I would deal with it.

Q. Can you give me an estimate of the percentage of your patients at your private practice that had rheumatoid arthritis?

A. It's an uncommon illness. It would affect just a few or 1 percent of the population that I was taking care of, I would guess. Maybe less than 1 percent. It's not a common illness.

Page 53

Q. When you had your private practice and you came across a patient or diagnosed a patient with rheumatoid arthritis, did you have to refer them to a specialist or did you continue to treat them for the rheumatoid arthritis?

A. I did not have to, no, and I did continue -- I would continue to treat them.

Q. During your time at Wexford, did you ever work solely as a physician at a site?

A. Yes.

Q. Okay. What was the time period in which you did that?

A. From 1995 to 1998.

Q. Based on your review of the literature on the standards of care for rheumatoid arthritis, if someone were diagnosed with rheumatoid arthritis, can you describe the treatment that you would recommend?

A. It would depend on the patient-specific circumstances, their findings as to what treatment would be appropriate. There is no general treatment or universal treatment that would be appropriate to apply to all patients.

Q. What types of information do you need to

Page 54

get from the patient to determine the appropriate treatment for rheumatoid arthritis?

A. Their history, their clinical findings, their laboratory findings, X-ray findings, the course of their illness, duration of their illness, response to any treatments that have been provided and adverse reactions perhaps to any treatments that have been provided.

Family history has some relevance. Comorbid illnesses, that is other illnesses that the person may have that may impact on their illness.

Q. Anything else?

A. The records. So that would include evaluations that were done by other physicians, their findings at the time. Sometimes family members provide valuable information that augments the patient's history. That is what comes to mind, but what you are interested in is all information that is relevant to that specific patient, and that varies significantly. Some patients, because of a stroke, are not able to speak, for example, so the information is gathered from other sources, relatives or records.

Page 55

But all information that is pertinent and based upon something coming up that may open the door for other information that -- that would be accessed or be queried.

Q. Are you aware of particular medications used to treat rheumatoid arthritis?

A. Yes.

Q. Okay. What are the ones that you are aware of?

A. They primarily are a group of medications called nonsteroidal antiinflammatory agents. Also, acetaminophen, which is Tylenol. Then there's another group of medications that serve to depress the immune response of an individual. Prednisone, methotrexate, and there is a group of newer diseases, biologic agents, that are also utilized and can be utilized in rheumatoid arthritis.

So there are many agents that are treated in a stepwise fashion. So we start with medications that have the lower side effect risk and profile, and based upon the specific findings of the patient that is being treated, it would dictate and determine which medications would be

Page 56

used.

Q. Are there any other treatment options besides medication for rheumatoid arthritis?

A. Yes.

Q. Like what?

A. Affected joints can be injected with cortisone. Other modalities are things like bracing, splints, crutches or canes that are used in ambulation. Physical therapy is sometimes used in patients, again, individualized to a specific patient. There are also other pain medications, simple pain medication, narcotic medications or narcotic-like medications, such as Tramadol that are sometimes used and, again, limited to specific patients and usually for limited periods of time.

Q. So for nonmedication treatments, you listed a few things, such as cortisone, bracing splints, physical therapy. Is there anything else that you can think of that you have not talked about?

A. Surgery might be used in cases where -- patients who have limited -- those extreme deformities that -- for those few patients that have an unfortunate severe case of rheumatoid

arthritis. You know, those would be the -- those would be the modalities that are used.

Q. Are you familiar with the Rh factor?

A. I'm familiar with an Rh factor, yes.

Q. Okay. In your experience, in your review of the literature, how is an Rh factor used in coming to a diagnosis of rheumatoid arthritis?

A. So, first of all, Rh factor refers to a blood antibody. That is -- the blood type is the Rh. It's also used -- it's actually RA for rheumatoid arthritis, but it is sometimes stated as Rh. The question that you are asking is about the rheumatoid factor, just to be clear. So rheumatoid factor is -- your question, I'm sorry, is what? You were asking about what?

Q. Yes. I can ask a better question this time. How do you use the rheumatoid factor in determining a diagnosis of rheumatoid arthritis?

A. It's one of the parameters that is looked at in determining what a patient's condition might be. So if a patient has symptoms that might be caused by rheumatoid arthritis or a related disease, that is a blood test that a clinician would order and then interpret in the setting of



that patient.

Q. So aside from rheumatoid arthritis, when might -- what other types of diseases would the rheumatoid factor indicate?

A. The elevated, you mean?

Q. Yes, if it's elevated.

A. About 100 other diseases.

Q. Are those other diseases related to rheumatoid arthritis, in your experience?

A. No. Most of them are not.

Q. Can you give me an example of some of these other diseases?

A. Malignancies. So any cancer may give a positive rheumatoid factor. Many inflammatory illnesses, endocarditis is a characteristic disease which will give a positive rheumatoid factor. But any severe infection may give a positive rheumatoid factor. And, again, hundreds of infections, and there's hundreds of malignancies and any of those could do that.

Now, it can also be found in a healthy individual that has no identified illness. The rheumatoid factor can be positive. And then, conversely, it's maybe not positive in patients who



have known rheumatoid arthritis.

Q. You mentioned that a healthy patient could have an elevated Rh factor. Do you know what the percentage of healthy patients who have an elevated Rh or rheumatoid factors is?

A. I don't believe that statistic is known because people would not test that. It's not indicated to test for people who are healthy, but it is occasionally done, sometimes by mistake. And then one looks at it and determines, finds out on asking the person, that they don't have any joint problems whatsoever, and nevertheless have a positive number. I don't think that statistic is known or could be known because, again, it would be inappropriate to do that testing.

Q. Sure. In your experience, what types of symptoms would cause you to test someone's rheumatoid factor?

A. Specific joint complaints that are characteristically seen in rheumatoid arthritis.

Q. Anything else?

A. Well, the joints involve the specifics of that. That is, the time of the day, the symptoms that they have, including things like



redness, inflammation, changes in the appearance of their joints, specifically their hands. There's a characteristic thing that happens to the joints and that the fingers will deviate outwards or ulnar deviation. Clinical findings consistent with rheumatoid arthritis, such as rheumatoid nodules, associated illnesses that may occur that are seen in rheumatoid arthritis.

Laboratory -- somebody who may have laboratory findings. Did you ask about symptoms only or things in general that would provoke you to test for that?

Q. My question was just about symptoms, but you can expand it to general.

A. So the first things that I mentioned would be -- the main thing would be the patient's complaints of joint pain, specifically the joints involved, the stiffness accompanying the pain. Those symptoms would prompt me to consider rheumatoid arthritis as a cause of the person's joint pain.

Q. And once somebody presents with elevated rheumatoid factors, what would be the next step in your investigation to determine whether that person

Page 61

had rheumatoid arthritis?
A. Well, if a patient has an elevated rheumatoid factor, that would be part of the evaluation of that patient, along with all of the other things that would be necessary in determining the relevance of that finding, beginning with the patient's history, starting when the patient's symptoms started, the specifics of their symptoms. Again, not just joint pain.
It varies according to what the cause is, whether it's pain in their knees or in their hands or where, whether it's one side or both sides. All of those things make a difference, what is associated with it, whether they have stiffness, whether they have swelling of the joints. Radiographic findings, and that would be dependent on the course of their illness. Like somebody who had symptoms early would unlikely have radiographic findings, but somebody that had longstanding would necessarily -- virtually necessarily have to have radiographic findings. Other blood testing, signs that are commonly associated with rheumatoid arthritis, but also may indicate other illnesses.
For example, if a person, like I

Page 62

mentioned, had a rheumatoid factor and had endocarditis, that would lead you to believe that that was the cause of the elevated rheumatoid factor. All of the information that I have previously mentioned is necessary to -- to review and to assimilate in determining the relevance of the rheumatoid factor.
Q. In your experience, if someone has a family history of rheumatoid arthritis, does that make it more likely that they might also be diagnosed with it?
A. Yes, it does run in family lines. It is more likely, assuming the diagnosis is accurate. It sometimes is not when a patient relays that history because patients sometimes refer to arthritis as rheumatism and confuse that with rheumatoid arthritis, which is not the same thing. So in my experience, I have had patients provide that history incorrectly. Their family did not actually have rheumatoid arthritis but actually had rheumatism and confused the two terms.
Q. Switching back for a quick second to your work as the regional director. Do your physicians have a way to verify medical history

Page 63

that is outside of the prison? For example, if an inmate comes in and talks about his prior treatment before incarceration.
Do the physicians have access -- are they able to go out and get those records from the physicians outside of the prison?
A. They are not able to get them. They can request them. The patient's consent is required, and then he obviously has to have the information as to where that care was provided. That often is missing. They don't remember the doctor's name or location, so there's no way of accessing it without that information.
But if they have that information, then a request for medical information can be sent, and if the records are available and the provider provides them, they can be sent.
Q. Okay. When you worked as a physician between '95 and '98, do you have a recollection of ever going out to get records on a patient that were outside of the facility?
A. Yes, certainly.
Q. About how often did that occur when you were a physician for Wexford?

Page 64

A. Whenever it was relevant for the illness. And most of our patients are -- well, people in prison are not there because they are sick. They are there because they committed a crime, so they are generally a healthy population that usually does not have a serious illness for which the records would be necessary, something like cancer, surgery from previous illnesses, but when that situation occurred, yes, records would be requested.
But it would not be done on every patient or where that information was unlikely to yield anything of any benefit. It was not simply done as an exercise because, again, it would not be fruitful and it would just be a waste of time for everyone.
Q. And so you have referred to several different diseases as serious medical disease. Would you classify rheumatoid arthritis as a serious medical disease?
A. The spectrum varies greatly. That is, somebody can have rheumatoid arthritis and no active symptoms almost from the illness, and then it can also be a very devastating, deforming

illness that may put somebody as bedridden. So it can vary.

In some instances, it can -- it certainly is a serious illness. In other instances, it's not -- people have the illness, if they were -- and are not aware of it. They are attributing joint pains to something else, so they live a relatively normal life, being unaware of their illness. So it varies significantly. I would not say that -- certainly not that all patients with rheumatoid arthritis are -- that it's a serious illness in all patients.

MS. REED: Okay. I think now is a good time to take a break. Can we go off the record?

THE WITNESS: Sure.

(WHEREUPON, discussion was had off the record.)

BY MS. REED:

Q. Dr. Funk, do you understand that you are still under oath?

A. Yes.

Q. Okay. We'll proceed.

When we were talking earlier, you mentioned that you participate in the litigation



hold process --

A. Yes.

Q. -- for your region?

A. Well, I, as an employee, participate in it, yes.

Q. I'm sorry. Can you say that one more time?

A. Not just for my region. As an employee, when I am sent a litigation hold, I respond to it.

Q. Okay. Now, for the litigation hold for this case, do you recall when that started?

A. No.

Q. Okay. What types of documents would have been included in the litigation hold?

A. Any that pertain specifically to the patient, so any that would appear from the inmate number, the Department of Corrections inmate number, that is the number that is queried, that is used in communication to identify a person, and I put that number in and then do a search for that.

Q. Okay. Now, when you do this search, would that include, for example, you know, e-mails between physicians and their site directors which reference an inmate?



A. Yes, if his -- if he was referenced and I received it, then yes.

Q. Well, let me ask that question again. I was saying e-mails between a physician and a site director, so not necessarily the e-mails to you as the regional medical director but the physician and the site director. Would those e-mails be encompassed in your litigation hold search?

A. Only if I was included in that. If I was not a part of that communication, then I would not. If I was included in it, then it would.

Q. Okay. Do you have a way to capture the e-mails that are not included, which reference the inmates?

A. I personally don't, no.

Q. But I assume the litigation hold would also go to the site director and the individual physicians involved with the inmate's treatment; is that correct?

A. Yes.

Q. Okay. And who makes sure that they preserve their e-mails with regards to the inmate?

A. Well, after they are sent to the risk management office, they preserve them. That is



their responsibility to preserve them.

Q. So if a litigation hold goes out to a number of physicians who are all involved with treatment of an inmate and one of those physicians does not respond, does risk management follow up with them to get their e-mails?

A. No. They are -- it would not be assumed that they have e-mails. That is sent to everyone. If they don't respond, it's assuming that they don't have -- they don't have anything to respond with, but they don't -- would not routinely, unless there was some reason to say, Well, you know, you have not responded because we don't respond with the negative or the fact that there is no information.

Q. Okay. In your experience as the regional medical -- as a regional medical director, are e-mails widely used to discuss treatment?

A. No.

Q. Okay. If a site director or physician would like your advice on a treatment strategy, how do they contact you?

A. By phone. Generally by phone.

Q. And if you need to review medical

records in order to provide advice, how do you get access to those medical records?

A. It would be from the physician relaying them to me as part of the discussion. It would be uncommon for me to review data. I would simply -- the conversation would include that information that he would relay, so it would be an exchange and I would talk to him and ask him what this showed or that showed. But it's not effective to transmit that type of -- that information electronically because it's an exchange. I would ask questions and he would respond to my questions, and he wouldn't know necessarily what my question was to be able to answer it in a written format. It would be cumbersome and not productive.

Q. I agree. I wish you would tell that to some of the partners that I work for.

A. I would be happy to.

Q. Now, in responding to the litigation hold for this case, do you recall whether you had e-mails with regards to the plaintiff?

A. No, I don't recall. I think he first filed it in 2015, and that is when the litigation hold would have been done. So it's five years ago.



I don't remember.

Q. Okay.

A. Or seven years ago. I'm sorry.

Q. In preparation for this deposition, did you go back and determine whether you had sent any e-mails with regard to this plaintiff?

A. I generally do that. I don't recall if I did it for this case. I may have done it, but I don't recall. I generally do that just for my own purpose, but I don't recall that I did or that I didn't.

Q. Other than e-mails and patient records and utilization management records and grievances, are there any other types of documents that you would expect to see as the result of a litigation hold for someone like the plaintiff?

A. Well, I would not expect those records that you mentioned in a litigation hold. I would not expect to see medical records, grievances. I would only expect correspondences specific to the patient from a clinician or from some other person in the system, but I would not expect all of those documents. As a matter of fact, those documents never occur.



But to answer your question -- I'm sorry again. What was your question?

Q. I was asking you if there were any other types of records that you would expect to see as a result of a litigation hold?

A. No. Just communications from a provider or a site regarding the patient, some concern regarding them, some event that had occurred.

Q. In preparation for the deposition, did you ask risk management for all of their documents that were being held as a result of the litigation hold?

A. Not specifically, but I asked the counsel for all of the documents relative to this case, that he provide them to me and that would include that. That has been the practice. I did not specifically voice that, but I have done many of these and it is that request that I always make to the attorneys representing these claims. And that would include that information certainly.

Q. Okay. When you reviewed the records in preparation for this deposition, was there anything that you did not receive that you would have liked to have in order to prepare?



A. The unknown, you mean? I don't know what I didn't receive. I only know what I did receive. There is nothing that I was expecting to have received that I did not receive.

Q. Okay. I want to switch gears a little bit. Have you met the plaintiff, Jovan Daniels?

A. Not that I'm aware of.

Q. Okay. And I'm just going to ask you about various parties and people or entities involved in the case and ask you about your familiarity.

A. Yes.

Q. So the late Dr. Saleh Obaisi --

A. Obaisi, yes.

Q. -- Obaisi. Were you familiar with him?

A. Yes, very familiar.

Q. And can you describe for me your relationship?

A. I was his supervisor. He was a medical director. I was his direct supervisor.

Q. So based on what we talked about earlier, you would have participated in his annual reviews; is that correct?

A. Yes.

Q. Okay. And are those reviews documented somewhere within the company?

A. I have seen written -- I have seen some that were written, yes. I'm not sure that they are always done written and in a written format, but I have seen some that were in writing.

Q. Let me ask my question another way. When you reviewed Dr. Obaisi, did you have to fill out a form for the annual review? Just to clarify.

A. We at one time did. Then the responsibility was shifted to the regional manager and that transition occurred, oh, probably eight or nine years ago, when the responsibility of the annual review was delegated to the regional manager. Prior to that, it was a written evaluation that was done that I would have done.

Q. Okay. And aside from being Dr. Obaisi's supervisor, did you have any other relationship outside of work with him?

A. No.

Q. And based on your familiarity from reviewing and supervising Dr. Obaisi, was there ever any corrective actions issued with regards to his decisions?



A. There was one incident I recall that had to do with his documentation that took place during the time that I was his supervisor.

Q. Sorry. Could you repeat that last part one more time?

A. During the time that I was his supervisor, there was one incident that I'm aware of.

Q. Okay. Did you know Dr. Obaisi prior to the time that you became his supervisor?

A. Yes.

Q. And during that time, do you know of any corrective actions that were issued to him?

A. There was an incident that occurred when he was at another site that I was not supervising that I became aware of somehow, and I don't remember how it was. But that I became aware of, but it was not clinical. It did not have anything to do with clinical -- it was not a clinical matter or a patient matter.

Q. Other than the two corrective actions that we have talked about, are you aware of any other corrective actions issued to Dr. Obaisi?

A. No, not that I'm aware of.



Q. Did you hire Dr. Obaisi?

A. I don't recall if I was involved with his hiring or not. He had worked for the company for many years. I don't recall my involvement with his hiring.

Q. Do you recall any involvement with his training?

A. No. He had been working for Wexford prior to my becoming his supervisor for a number of years, so I would not have been involved.

Q. Okay. In your supervision of Dr. Obaisi, can you think of a time where you disagreed with the diagnosis that he made?

A. I can't recall a specific time, but physicians often disagree on diagnoses. That is a very common -- when we render an opinion, but I don't recall a specific instance or an adverse result as to our difference that may have occurred.

Again, I don't recall, but, again, it's very common that -- physicians are required to use their own judgment. And in that, that judgment will differ, and it's not -- it's not unusual to have a difference in a diagnosis.

Q. Similar to lawyers. We disagree about



how to do things.

A. Yes. Right, right.

Q. Have you reviewed Dr. Obaisi's progress notes for the plaintiff?

A. Yes. I reviewed the records, and I would have reviewed his notes, yes.

Q. As you sit here today, do you recall anything that you disagreed with, any recommendations that he wrote in his progress notes that you disagreed with?

A. That I disagreed with him offering at the time or my opinion of what his -- what the diagnosis was or the impression was of the patient's condition? Those are two different things.

Q. Let's start with the latter.

A. I don't know -- I don't recall specifically if his impression was that the patient had rheumatoid arthritis. I know it was a consideration. I don't recall, and I did not really review that with that in mind. But if his impression was that he had rheumatoid arthritis, and it may have been, I would disagree with that. My impression is that the patient does not have

rheumatoid arthritis.

Now, whether that opinion would have been done contemporaneously, I don't know. I have the benefit of retrospect and knowing things that Dr. Obaisi didn't. That is, the fact that he did not improve with the treatment and subsequent -- his subsequent course and opinion -- other findings of physicians that had seen him years later, so I have a completely different perspective than Dr. Obaisi had. But my opinion is -- it would be different if Dr. Obaisi felt he had rheumatoid arthritis.

Q. Okay. So can you give me a little more detail about why, if you -- let me strike that.

Assuming for the purposes of this question that Dr. Obaisi believed that the plaintiff had rheumatoid arthritis. Are you saying now that you would disagree with that assessment? I guess I'm just trying to make sure what your disagreement is.

A. Yes, I would disagree with that, if that was, in fact, his assessment, which I'm not saying that it was. I don't know. He did refer him to a rheumatologist, but that does not mean that he



believed that. People refer -- doctors refer patients for opinions, and that does not mean that he was in belief but he certainly considered it as a cause of his symptoms.

Q. And why do you think that the plaintiff does not have rheumatoid arthritis?

A. For a number of reasons. The clinical picture does not fit rheumatoid arthritis. The only thing is that he has a slight elevation in rheumatoid -- in his rheumatoid factor. He characterizes it as out of range. It's not out of range. It's in range, but it's beyond what is typically seen in a healthy person.

But his history does not fit rheumatoid arthritis. His laboratory parameters do not fit rheumatoid arthritis. His clinical course does not fit rheumatoid arthritis. His lack of response to methotrexate -- well, I would say actually his symptoms, from my review of the record, actually worsened after he was given methotrexate. The lack of radiographic findings and the duration of time that he has had an abnormal rheumatoid factor, an elevated rheumatoid factor is not consistent with rheumatoid arthritis.



His current most recent findings by the physician that he saw in the Cook County system, his documentation of his symptoms, his findings, and also it was -- although I did not see it, I just got the records yesterday afternoon, but it was stated by the physician that his rheumatoid factor was negative in the note.

I looked for that and I could not find the actual report, but it is stated in the last visit, recognizing that he had previously had, by his history, an elevated rheumatoid factor, and he had mentioned that the rheumatoid factor was negative.

So those things -- so the whole thing together all speaks against rheumatoid arthritis as being a reasonable disease for Mr. Daniels.

Q. Okay. I'm going to dig into some of those -- the things that you listed.

A. Yes.

Q. So one of the things that you talked about is his rheumatoid factor levels, and my understanding of what you said -- and correct me if I'm wrong -- is that his levels were only slightly elevated?



A. Yes.

Q. Okay. And so why does that to you indicate that he did not have rheumatoid arthritis?

A. There is a correlation with the degree of the titer. That is, how highest it's elevated and the likelihood of the patient having the illness as opposed to it being caused by another condition or by no condition at all. So he is in the range where it's not significantly elevated, and that would be defined as less than three times the upper limit of normal.

Q. And you mention that his history also causes you to believe that he does not have rheumatoid arthritis. What about his history supports your conclusion?

A. Well, I also mentioned -- I think you missed this. I mentioned the other factors that were not present, other laboratory factors that were not present, typically seen in rheumatoid arthritis. I just want to clarify that it's not simply the rheumatoid factor in him that was looked at, but the absence of other laboratory parameters that are characteristically seen in rheumatoid arthritis were not present in Mr. Daniels.

Q. That was my next thing on the list.
A. I'm sorry.
Q. That's okay, but that makes sense to talk about it now. So there was an absence of other factors that would typically indicate rheumatoid arthritis; is that what you are saying?
A. Laboratory. Specifically laboratory. Also, radiographic X-ray but specifically laboratory were absent.
Q. So what laboratory factors would you expect to be present if someone had rheumatoid arthritis?
A. They are inflammatory markers, something called a sed rate. It's abbreviated ESR. Another parameter, I don't remember if they mentioned it was measured, but something called C reactive protein.
Those numbers are inflammatory markers and are usually very elevated, reliably very elevated, and inflammatory conditions, such as rheumatoid arthritis, when someone has rheumatoid arthritis, active rheumatoid arthritis. I know his sed rate was consistently very low, which is just not consistent with rheumatoid arthritis. I don't



recall what his C reactive protein was.
There's another antibody called anti-CCP that is characteristically seen in rheumatoid arthritis as a positive. He was negative. Other things that are commonly seen are results in inflammation resulting in anemia, specifically a type of anemia called anemia of chronic disease. He was not anemic and depressed protein, as another phenomenon that occurs in people who have inflammatory diseases, such as rheumatoid arthritis, and specifically albumin will be depressed. He did not have a depressed albumin.
So of the many laboratory things that I looked at, he only had one, and that was only a weekly positive finding.
Q. The other laboratory factors that you just named, were you looking at the results from the time that he was incarcerated, or are you referring -- I guess I just want the time period.
A. I looked at every record, every page, so that was the 15 years that he -- 12 years. 2005 to 2017, I think, when he was released. I looked at all of those records and also the records that were just provided yesterday afternoon, but I just



scanned through them. I did not have time to look at them very carefully.
Q. Okay. So it's your testimony that the inflammatory factors that you would typically expect to be elevated were not for the plaintiff?
A. Markers, yes. Inflammatory markers were absent, yes.
Q. Okay. Now switching back to the history, what about the plaintiff's history causes you or adds to your conclusion that he does not have rheumatoid arthritis?
A. His history being inconsistent with the history of somebody who has rheumatoid arthritis and him having an explanation -- other explanations for what his symptoms might be attributable to.
Q. Okay. What would you expect from a person who does have rheumatoid arthritis?
A. They typically will have symmetrical pain and stiffness. They will complain of the two. Their hands are almost always involved, and because of the use of the hands, it becomes a complaint that people have and it will be consistent that they will have stiffness and pain of the joints of the hand, particularly the MTP joints, metatarsal



phalangeal joints, the knuckles of the hands and then lesser to the fingers, the PIP joints and of the wrist.
They will characteristically have early morning stiffness and pain. Grasping will be painful, and they may have weakness. That is another complaint that is characteristic of people who have rheumatoid arthritis. It rarely affects the joints he complained about, his back and elbow. It does sometimes, but it was just one elbow.
And his complaints, when he complained of joint pain, were infrequent relative to his other complaints, and they were not typical of somebody who is a rheumatoid patient.
Q. You also mentioned his clinical courses?
A. Clinical course, yes.
Q. Sorry. One more time?
A. Clinical course.
Q. Clinical course is one of the things that you considered in forming your opinion that he does not have rheumatoid arthritis. What about the clinical course contributes to your opinion?
A. So a patient who has especially untreated rheumatoid arthritis, that is without an

immunosuppressive agent, their illness would be expected to progress, and that would show -- result in clinical findings that the disease worsens and radiographic and laboratory findings.

So all of those things should expand over time, amplify over time. So having the benefit of looking retrospectively at what occurred and currently what his status is, he does not have findings, even in the present day, after having had this elevated rheumatoid factor for, what, at least 10 or 15 years. So that is, again, completely inconsistent with it being a diagnosis of rheumatoid arthritis, and especially in the face of him not being on any immunosuppressive agent which could have slowed down the progression of the illness.

In addition, when he was -- except for that short period of time, three months or so. And then during the time when he was on a medication for which symptoms would be expected to resolve or mitigate, his symptoms actually amplified. He complained more about joint pain during the time he was treated with the agent which is used to reduce the symptoms of rheumatoid arthritis, and he even



acknowledged that in his subsequent notes, that it was ineffective.

Q. What is the agent that is used to reduce the symptoms of rheumatoid arthritis?

A. Well, the immunosuppressive agent that I was referring to was methotrexate.

Q. Okay. Now, I think that moves us on to our next one, lack of response to the methotrexate. What response would you have expected to see?

A. Well, from reviewing the record, he didn't have a diminution in his joint pain that would have been expected to have occurred. So either there would have been no improvement but likely there should have been an improvement. But what actually happened was, there was an increase in his complaints of joint pain that occurred during the time that he was receiving the treatment, which, again, is completely inconsistent with rheumatoid as a diagnosis.

Q. Then in the Cook County documents, you mentioned that the -- there was a negative rheumatoid factor?

A. I mentioned it was in the note of the physician that there was a negative rheumatoid



factor. I did not actually see the result. I could not find -- even though there was some -- laboratory results were submitted, I did not see it. But, again, I did not have much time to look at it.

It's actually -- the last sentence of the last visit states that rheumatoid factor is negative, and it acknowledges that it had been positive.

Q. The fact that it was -- or that there's a progress note talking about the rheumatoid factor being negative, how does that factor contribute to your opinion?

A. It just strengthens it. I would not change it. I would not expect that it would be negative. That surprises me a little bit, but it does not alter my opinion. It would, if anything, just strengthen it, but it doesn't change it.

Q. Why does it surprise you?

A. Generally, if it was positive for the length of time that it was, from the lab reports that I had seen, whatever is causing it to be elevated, I believe, is still there. He's the same biologic person, and then whatever -- it generally



does not just disappear. It is present in some individuals and it's unexplained. I mean, it's associated with certain illnesses, but in some people it's just present and it's not known why, but they generally have it. It does fluctuate, as it did in this case, but it usually does not become negative once it's elevated.

Q. In your experience, are there certain environmental factors that could cause someone to develop rheumatoid arthritis?

A. No. Not external environmental factors, no.

Q. Okay. Was there anything else about the clinical picture, other than the things that we just talked about, that contributed to your opinion about the diagnosis of rheumatoid arthritis?

A. I mentioned -- I'm sure I mentioned the findings of the physicians and their opinion of those that had seen him recently, subsequent to his parole or release from prison, what their findings were and opinion about his -- what the cause of his symptoms were. That also played a role in my opinion.

Q. Okay.

A. Another thing I would say is, what also moved my opinion was Mr. Daniels' deposition, where what he stated was, when he was asked why he was filing a lawsuit, he stated because he had an elevated rheumatoid factor and it appeared to me that he -- his belief has been influenced by that laboratory result as patients sometimes are. They believe they have the disease because they have this laboratory finding, which is often seen in the disease, and they attribute or believe they have the disease.

So his belief is that he has the illness, and, therefore, may attribute some of his symptoms or suggest that some of his symptoms may be related to that and that that seemed to happen, from the interview with the rheumatologist, where he had asked him some questions of rheumatoid symptoms that he responded to but were not actually elicited by Mr. Daniels over the many years he had seen providers in the prison system.

So I believe he's been -- it was suggested to him or he believes that he has the illness, and, therefore, some of those symptoms that he's relaying are things that he believes



would be consistent with that or his judgment has been prejudiced by the laboratory data that he has.

Q. A few follow-up questions. Does methotrexate impact your rheumatoid levels at all?

A. It may. It may actually depress the level. It's -- again, that is not the purpose of the medication, but it may reduce the titer of the rheumatoid factor.

Q. And in your experience, have you ever seen patients who did not have the typical inflammatory markers but in your belief did have rheumatoid arthritis?

A. Yes. The disease can -- has a wide range in its presentation, but characteristically those are the findings that you would -- that were discussed. Those are the findings that you expect to see.

There are patients who have inactive disease that may have rheumatoid arthritis but not have an active form or the manifestations of that. That does exist, but the common presentation is the person that has those other findings.

Q. And in your experience as a physician and medical director, have you seen patients who



have rheumatoid levels that are not significantly elevated but they still, in your belief, possess the disease?

A. That can exist, yes. Again, it's looked at as one of the parameters in making that judgment. It would be inappropriate to make a determination solely defined on their rheumatoid factor or their level.

Q. Okay. I'm going to go back to the various employees. Are you familiar with a Paul or a Dr. Paul Williams?

A. No.

Q. Okay. Are you familiar with a Dr. Adrian Feinerman?

A. Yes.

Q. Okay. What is your familiarity with Dr. Feinerman?

A. He was a medical director at a facility that I did not supervise, but I knew of him from meetings that we had. I knew he was the medical director there.

Q. Okay. Is he still the medical director?

A. No.

Q. Okay.



A. I believe he -- he may have passed, but I'm not -- I heard he had a stroke, but that was years ago.

Q. Okay. What about a Dr. John R. Shepherd?

A. Yes.

Q. And how are you familiar with Dr. Shepherd?

A. He was a doctor that I had met at company meetings. He was a physician that worked at other facilities but not that I was direct supervisor of.

Q. Okay. What about Rashida Pollion?

A. Spell that, please. What is the last name?

Q. P-o-l-l-i-o-n.

A. I don't know that person. I don't believe -- it's probably a nurse, but I don't think that I know that person.

Q. Okay. And does your supervisory duties include supervising nurses?

A. Not directly, no.

Q. What about Mikhail Magdel?

A. Dr. Magdel, yes, I do know him.

Q. And what is your familiarity with Dr. Magdel?

A. He was a -- I know I interviewed him, and I know he had worked as a physician for a number of years, but not at a facility that I supervised.

Q. What about Kimberly Criss, C-r-i-s-s?

A. I don't personally know that individual.

Q. Okay. What about LaTonya Williams?

A. I do know LaTonya Williams. She's a physician assistant at Stateville or was.

Q. Okay. And do you have any supervisory duties with respect to LaTonya?

A. Not directly. It would be a facility in my district, but I would not be her direct supervisor. The site medical director would be.

Q. With regards to nurses in your facilities, if there was a corrective action issued, would you have been notified?

A. Depending on the subject matter. I may have, but, generally, no, I would not. For minor issues, I would not be involved with that.

Q. Okay. Are you aware of any corrective actions issued to Ms. Williams?



A. I believe that there was for attendance. She was coming late. I'm certain there was. I know there was some matter or issue relating to her coming late in the morning, arriving late at work.

Q. Anything else?

A. That's all I recall.

Q. How about Dr. Liping Zhang?

A. She was a physician at the facility, at Stateville.

Q. And did you supervise Dr. Zhang?

A. No, not directly.

Q. Okay. Do you recall there being any corrective actions against Dr. Zhang?

A. Yes.

Q. Okay. For what?

A. I recall a clinical matter for which she was disciplined and possibly terminated, and I don't recall if she was disciplined and then resigned or she was actually terminated.

Q. Do you recall what the circumstances of that clinical matter were?

A. Not the details of it. It was -- this would have been about seven or eight years ago, maybe longer, so I don't remember specifically.



Q. Is there a limit on corrective actions that you can receive before you are terminated?

A. The number?

Q. Yes.

A. No, it's a progressive discipline. So it progresses, depending on what the matter is, and it progresses to termination, if that is indicated.

Q. Okay. What about Dr. Fe Poblete Fuentes?

A. Dr. Fuentes. I am aware of her. She was at a facility, Menard, that is not in my district. I was aware of her as a physician at the facility, but that is all.

Q. Okay. What about Dr. Samuel Nwaobasi?

A. Again, I know of him as a physician at Menard, which is a facility that I did not supervise, so I don't have direct -- did not have direct involvement with him. I just knew of his presence or employment with Wexford in that capacity.

Q. What region is Menard in?

A. Southern. Southern part of the state.

Q. Okay. Who is the supervising person for that region?



A. Presently, it's Dr. Glen Babich, B-a-b-i-c-h.

Q. Okay.

A. But at the time, it would have been somebody -- he has been in prison for a long time, so up until two years ago, we had two regional medical directors. The state was divided north and south. The southern would have been Dr. Rob Matticks, M-a-t-t-i-c-k-s, and Menard would have been in his district. Two years ago a third regional medical director was added, and we divided the state from two into three.

Q. Did you ever work in the southern region during your time at Wexford?

A. No. No, I never worked in the southern region, but there was also a time between regional medical directors, where I was the only regional medical director. That was only about, I think, maybe six months or so, until they hired the second regional medical director, or the one -- the previous one had left, and I was the only one for about six months.

Q. Do you recall about when that was?

A. It would have been about early 2000s,

like 2008, I think. 2008, 2009, I'm guessing, around there.

Q. Is it fair to say that the various regions are all governed by the same guidelines in Illinois?

A. Yes. Yes. Individual facilities have individual makeups, so they have different missions, but generally that statement is true.

Q. Okay. So let me ask a better question. So for Stateville, for example, is there a written set of guidelines that Wexford employees would refer to or look at?

A. Yes. So it's Stateville. There's no second S, but everyone thinks there is. Yes, there are -- there are guidelines that apply to the entire state, and then each site will have specific guidelines for its specific needs.

Q. Okay. Are you familiar with a Dr. Robert Shaefer?

A. Yes.

Q. Okay. And --

A. It's Ronald. Ronald Shaefer, it should be.

Q. It's Ronald. Okay.



And you indirectly supervise Dr. Shaefer?

A. Yes. Actually at one point directly. He had different positions in the company.

Q. Okay. And do you recall any corrective actions being issued to Dr. Shaefer?

A. Not that I recall, no.

Q. And the corrective actions, is that a written notice?

A. It could be written or verbal. Generally, it would be done in writing, memorialized in writing.

Q. Okay. Are you familiar with a Dr. Magid Fahim?

A. Yes.

Q. What is your familiarity with Dr. Fahim?

A. He was the medical director at Menard for a period of time.

Q. Did you have any supervisory duties with regards to Dr. Fahim?

A. No. The only exception, in that brief period of time when I was solo in the state, that if that happened to coincide -- and I don't remember if he was medical director at that time,



but that would be the only time that I would have been his direct supervisor.

Q. What about Dr. Arturo Sevilla?

A. I know a Dr. Sevilla, but it was not Arturo. It was -- it was a female. I don't remember her first name though.

Q. And how do you know Dr. Sevilla?

A. She was a staff physician at -- at Stateville Correctional Center but only for a brief period of time.

Q. Does Dr. Sevilla still work at Wexford, to your knowledge?

A. No, she does not.

Q. Do you know when Dr. Sevilla left?

A. I don't recall the dates, no.

Q. Are you aware of any corrective actions issued to Dr. Sevilla?

A. No, I'm not aware of any.

Q. Do you know why she left?

A. No, I don't recall. It's not for everybody. Corrections is a unique environment, and some doctors just don't like it.

Q. Fair enough. Okay. We are about to turn to the procedures or some procedures handbook.



Let's see. I will mark the Wexford Health Provider Handbook as Exhibit No. 2, and I will share my screen.

Dr. Funk, can you see my screen now?

A. Yes, I can.

Q. And I will --

A. Better. Thank you.

Q. Okay. So we are looking at Exhibit No. 2, which is the Wexford Health Provider Handbook, so I'm just going to ask you some background questions about this.

So, first of all, do you know who puts together this provider handbook?

A. The person who signs it. There's a signature on the second page. So it's put out by the corporation, but the person who reviews it and updates it -- it should have a signature on the second page. It probably is the corporate medical officer, chief medical officer.

Q. Okay. Let's see.

A. There it is.

Q. So Dr. Thomas Lehman, the corporate medical director?

A. Lehman, yes.

Q. Does anyone else review it besides Dr. Lehman?

A. Whoever he chooses. He's the one who does the final review and issues it. He may give it to other individuals for their opinion. Actually, I have been asked to give an opinion on the -- and make changes to the physician handbook, but it's at his discretion.

Q. Okay. And what is the purpose of this handbook?

A. It's used in orientation of a new provider to give them information about the company and corrections and the specific population that we provide services to.

Q. Can you give me more detail about how it's used in training?

A. Yes. It's handed to the new applicant as a prospective employee to review, and it is reviewed -- I review it with the providers during my orientation with them.

Q. Are you --

A. I'm sorry. And in that review, they have the opportunity to ask questions about any of the contents of the handbook.



Q. Do you have this particular handbook? I believe this is the one effective November 21, 2016, with you or near you?

A. No.

Q. Okay. We'll keep it up on the screen then.

Now, you mentioned that you hand this handbook to the people that you are training and go through it with them. Are there particular sections -- and I'll look at the table of context -- that you go through with physicians?

A. No. I hand it to them in advance, ask them to read it, and then I go over it with them page by page or section by section and ask -- give them the opportunity of asking any questions relative to those areas.

Q. Okay. Just so I understand, you go over the entire handbook with them?

A. Yes.

Q. Okay. To make things easier, when I refer to it, I'll highlight it so you can see what I'm talking about.

A. Okay. Could I ask for maybe one more magnification? Okay. Great. Thanks.



Q. So I highlighted a particular passage on page 3 of Exhibit No. 2.

A. Yes.

Q. It says, All readers are encouraged to consult their site specific operational policies and procedures with regards to facility protocols. Did I read that accurately?

A. Yes.

Q. When you train physicians, do you hand them a copy of their site specific operational policies and procedures?

A. Some of them. Yeah, some of them would be at the facility, and they would evolve. They would receive those during time, and some of them they would receive in training from other individuals. But some of them, yes.

Q. Going to page 5 now of this handbook. If you look at letter E.

A. Yes.

Q. Is there a chronic clinic for rheumatoid arthritis patients?

A. Not specifically for rheumatoid arthritis patients. There's a general medical clinic in which a rheumatoid arthritis patient can



be added to, where they would be seen on a scheduled basis, but there's not specifically a rheumatoid arthritis clinic.

Q. How would an inmate get added to that specific medical clinic, where they could be seen on a regular basis for their rheumatoid arthritis?

A. At the discretion of the clinician, if they chose to see him in a structured clinic, such as the general medical clinic, they could do that by assigning them to the clinic. That would be something written that would indicate them to be added to the general medical clinic.

Q. In your experience, if a patient was experiencing active symptoms with regards to rheumatoid arthritis, would you find it acceptable for a physician to refer them to the general medical clinic?

A. Yes.

Q. I just highlighted a particular passage on page 5. Do you see this reads, Wexford Health has an extensive manual on chronic care clinics to help you with the management of these disease states. Do you see that part?

A. Yes.

Q. Is there a manual for the general medical clinic?
A. No.
Q. As you sit here today, do you know of a manual that specifically references how to care for patients with rheumatoid arthritis?
A. No. Not a manual, no.
Q. You are saying not a manual. Is there other documentation?
A. It may be in the medical guidelines. It may be mentioned in the medical guidelines. I don't know that offhand. I did not have time to review that.
Q. Is that something that you would typically review?
A. Review in what sphere, in what setting?
Q. In preparation for a deposition.
A. I would review all information that was provided and relative to the deposition, so, yes, I would generally review that, if I had the time.
Q. Now moving on to page 6 of Exhibit No. 2. I highlighted a particular paragraph. Sorry. My computer is being -- give me one second.
A. Sure. It's way too small. You are



going to have to blow it up, but I do see it, that it is there.
Q. I need to blow it up, is what you said?
A. Yes. Yes, please.
Q. Okay.
A. Now what is happening is, it's getting cut off, as it's getting larger.
Q. Let me -- I know what I can do. Okay. Can you see it now?
A. Yes.
Q. Now, I highlighted a particular passage, and I'm going to start reading below that passage though and then come back to it.
A. Okay.
Q. Starting with what is marked as A, Many variables must be considered when deciding a course of treatment. These include but are not limited to the following. Did I read that accurately?
A. Yes.
Q. Now, I'm going to skip down to letter D. Letter D is, Whether the problem initiated in the Department of Corrections or prior to incarceration. So why is D relevant when considering -- when deciding a course of treatment?



A. To define what the condition is and what the course of action should be. The time of when the illness developed would be relevant and it would -- the decision of treatment would be impacted by their current incarceration status.
So some conditions that are longstanding would -- the impact of incarceration would impact on the decision of treatment or what type of treatment would be relevant.
Q. So let's go to letter F. How long is the inmate's sentence? When will he or she be released? Why is that an important variable to consider when deciding a course of treatment?
A. There's something in medicine called continuity of care. That is when a condition is treated, the effort should be made to complete the course of treatment, so that if a person has a complication, they are under the same care of the same provider. Incarceration for most instances is a temporary housing situation, where they are housed from a place where they don't reside. So should they have a complication from treatment or should their release not allow the treatment to be completed, that could negatively impact on their



care.
For example, this comes up for treatment for Hepatitis C, which is a very costly treatment, and it is generally not accessible in the community because of its cost. But because it's a viral illness, it has an adverse result to have that treatment interrupted, and knowing that a person is going to be released would be a reason not to implement treatment while they are incarcerated because it would actually worsen the illness when it was incompletely treated. It could cause a viral resistance to occur.
Similarly, if a person is not there to have the treatment completed, it would be -- you know, for example, in surgery, the physician would need to know that the person was in the facility or in custody for a procedure to be done and scheduled. It often takes months before a procedure can be -- with all of the necessary preoperative things that need to be done and the scheduling, you would not want the person to be released shortly before surgery or not have the surgery -- be able to accomplish the surgery while the person was incarcerated. So the date -- the

length of time that the person will be a patient of the physician is relevant.

Q. Is that consideration relevant when it comes to treatment for rheumatoid arthritis, in particular prescribing methotrexate?

A. It may. If I had a patient who was soon going to be released, I probably would not start them on methotrexate because it's an immunosuppressive drug that requires monitoring, and it could potentially harm a patient where they likely will not have access to a provider in the community. But it would depend on the individual circumstance. If the person said they did have a physician -- which most of them don't, but if they happened to say they would, then I would not have that concern.

But there is concern, particular concern, with that medication because of its immunosuppressive -- it depresses the person's resistance against fighting off infections. And, again, it would depend on a number of other factors. The general health of the patient, their age. There's a number of factors that would be considered and impact on my decision to treat



somebody or not.

Q. Okay. And in a similar scenario where someone is temporarily transferred to a facility but that is not their home facility, would you delay prescribing methotrexate until they got back to their home facility?

A. Perhaps. It depended on where they were transferred and how long before they were going to be released. Whenever there's transition, it opens up the door for something not going right. It just increases the possibility of miscommunication of that.

So there is a general principle that you try to -- you take those factors into consideration, and it's best to have the person at one site for treatment with oversight of one provider rather than adding other people, but it's not a strict consideration. It's not something that would always be done. Again, it would depend on what the medication was, what the purpose of the medication was, how much the person needed the medication, you know, what the -- all of those factors would make -- would be relevant.

Q. Do you know if methotrexate -- am I



saying that right?

A. Yes. You got that one right. Very good.

Q. Do you know if that is available in the commissary at --

A. No.

Q. Sorry. Go ahead.

A. I cut you off, but you were saying is it available at the commissary?

Q. Yeah. I asked, is it available at the commissary?

A. No. No, it is a prescription drug. It is not available in the commissary. It can only be issued with a prescription by a physician or a provider.

Q. And walk me through how the inmates, if they are prescribed that medicine, how would they receive it then?

A. They would receive it from a nurse that would either provide it on a daily basis and most likely would be provided that way. Or it can be issued on what is called a blister pack, which is a card that has little bays of the medication, where the patient pushes through the plastic bay and it



pops out the back through foil, and they would take it themselves. It depends on how the physician would order it. This medication generally is a witness dose medication or a nurse administered medication rather than a keep-on-person medication, as the other example.

Q. For methotrexate, if it's issued on a daily basis and you skip doses for various reasons, in your experience, are there side effects?

A. There are not side effects. It's less effective because the medication is not in the system, but it would actually be the opposite. There would be less side effects or potential for side effects if it's not taken. The side effects arise from taking the medication, and invariably it depresses the immune system.

Q. Okay.

A. That is not a side effect. That is a result of taking the medication and a concern, therefore, of the medication or the use of the medication.

Q. We are now moving on to page 7 of Exhibit No. 2. I'm going to ask you a few questions.

Are you familiar with the National Commission on Correctional Health Care standards?

A. Yes.

Q. And are the most recent standards provided to the physicians that work at your sites?

A. They may have the standards at the facility, but many of them have them -- have obtained them on their own because they have the certification, the CCHP certification, and the standards are part of the certification. Review of them is necessary for the certification. Most of our providers are CCHP certified.

Q. Do you recall whether Dr. Obaisi was CCHP certified?

A. No, I don't recall.

Q. What about the American Correctional Association standards, are your physicians provided with those standards?

A. They may be at the site, at the facility. We do not provide them directly as a company policy. We do not provide those standards. The facility may have them at the site, but we don't provide them.

Q. Okay. Now, there's something in



Section IV referred to as the negotiated health service contract. Do you see that?

A. Yes.

Q. Okay. What is that?

A. That is the contract that exists between Wexford, the Illinois Department of Corrections, and Health and Family Services.

Q. And are the physicians provided with a copy of that contract?

A. It is at the facility. It is also online, yes.

Q. You said it's also online?

A. Yes.

Q. Okay. Do you have separate employment agreements with each of the physicians that are employed at the site?

A. Yes.

Q. And do you have separate employment agreements with each of the nurses that are employed at the site?

A. Yes.

Q. I assume those are written agreements; is that accurate?

A. Yes.



Q. Now, on page 9 of Exhibit 2 -- and I'm highlighting the passage for you. So this is Section I on page 9 of Exhibit 2. And the passage that I highlighted says, At your disposal are two cardiologists, a Hepatitis C and infectious disease specialist, a nephrologist, a rheumatologist, an internist, a family practice physician, and a wound care specialist. Did I read that accurately?

A. Yes.

Q. Who is the rheumatologist that you would go to for your region?

A. I'm not sure I understand the question. What do you mean in my region?

Q. I'm sorry. I missed the last part of your response.

A. I'm not sure what you mean by "the rheumatologist in my region."

Q. Okay. Let me ask a better question.

Who are these corporate medical directors that are referred to on page 9?

A. There's a number of corporate medical directors, so they would be situated in the corporate office in Pittsburgh.

Q. And is one of them a rheumatologist?



A. A rheumatologist was not a corporate medical director. He was a physician, but he was not a medical director.

Q. So who is that rheumatologist then?

A. His name escapes me right now. It might actually be on the bottom of the document, if you go all of the way to the end, if you want to do that. I believe it's listed there.

Q. All of the way at the end of the document; is that what you are saying?

A. Yes. I believe if you go all of the way to the end, his name would be listed with the extension or contact number.

Q. Okay. When we get to that part, I'll show it to you and ask you --

A. Okay.

Q. -- if it jogs your memory.

So we are on page 12 of Exhibit No. 2, and under Interview Techniques, No. 2 says, Have as much knowledge as possible at hand when you start the interview. Review the inmate chart (if one is available). A few minutes of chart review will save you considerable duplication of work and evaluation. Did I read that accurately?

A. Just a second, please. My computer is telling me my battery is running low. I have to make sure that I'm plugged in here.

Okay. I think I'm plugged in now. I'm sorry. Could you please repeat the last question?

Q. Yes, I can. So I was reading under Section B, Interview Techniques, No. 2 says, have as much knowledge as possible at hand when you start the interview. Review the inmate chart (if one is available). A few minutes of chart review will save you considerable duplication of work and evaluation. Did I read that accurately?

A. Yes.

Q. During your time as the regional medical director, have the inmate charts been in paper format?

A. Yes. The majority of them have been, except for the female system, which is on a computerized system.

Q. Can you say that last part one more time?

A. The female sites are computerized, but the male sites, which are the majority, are paper.

Q. I want to scroll up. So one of the



things that I have seen in this handbook a couple of times is references to inmates and manipulation. Why is it important when you are training physicians to discuss this?

A. Because it's a consideration in treatment of a patient, that some can be manipulative, and that is a factor that is considered in treating patients.

Q. And how is that factor considered in treating them?

A. It's a factor that is considered in determining what treatment should be appropriate for a specific patient, so it is something that is relevant in interactions with a patient, that one would consider that they may be manipulative.

Q. Okay. Let's move on to the next page. So I'm looking at No. 8, and I'm going to highlight some text from that. So No. 8 says -- the first three words are in all caps -- DO NOT EVER explain symptoms you would expect to see to confirm a diagnosis to an inmate. If you should, those symptoms will likely be present with the next visit. Did I read that accurately?

A. Yes.



Q. Okay. And what is the purpose behind this recommendation in particular, those two sentences that I read?

A. So some patients can be suggested to have an illness from symptoms that are explained by a clinician. About a third of our population have mental illness, and that population or patients who have mental illness can -- are suggestible to be -- to sometimes believe they have symptoms that are suggested from an interview. So in our -- for that reason, that is why this statement is written. It's advised not to suggest symptoms, but rather to ask open-ended questions of what a person has. Not suggest, for example, do you have this? Because a tendency in some patients is to answer yes to any question.

Q. Okay. And so in that situation, in your experience, are there times where an inmate may have symptoms that could help your diagnosis but just doesn't know to verbalize those particular symptoms?

A. No. I would say they may not be able to explain it in the way that is -- another person might be able to, but they are able to communicate



what their symptom is, just using different words that you might see from another person.

So, no, I don't think that there's any restriction or limitation on a person being able to express those symptoms, and if the physician thought that, they could ask the question or suggest something. These are -- this is a general guideline. It does not apply, as the preface states, to every specific patient.

Q. So in your experience physicians might ask questions about particular symptoms if they thought it was appropriate?

A. Yes. Yes, absolutely.

Q. Moving on to page 15 of Exhibit No. 2, and at the top, Section I is Intake Reception and Classification?

A. Yes.

Q. I'm going to highlight the first sentence of the second paragraph, which reads, Within 14 days following the intake screening, a complete history and physical examination should be completed, including whatever routine and other indicated laboratory and biometric testing is indicated to establish claimed problems. Did I

read that accurately?
A. Yes.
Q. Is it fair to say that you would expect each inmate to have a full complete history and examination in their file from their intake?
A. Yes, except if they refused it.
Q. How often do inmates refuse it, in your experience?
A. The intake physical, not that commonly, or they may refuse a part of it. There's an unpleasant exam that used to be part of the exam, called a rectal exam. That is commonly refused, but the entire exam, just a few percent will refuse the exam completely.
Q. Okay. Going to page 17 of Exhibit No. 2. I'm highlighting the last sentence of the first paragraph on that page that reads, If you, as responsible physician, believe specialty services are indicated and identify a medical need, the case must be discussed in collegial review. Please review the utilization management policies and procedures for all off-site care. Did I read that accurately?
A. Yes.



Q. Now, as we discussed earlier, the collegial review process is no longer in place as of today; is that correct?
A. Correct.
Q. But for the entire time that you have been medical director, so since 2005, up until about six months ago, the collegial review process was in place; is that correct?
A. Nine months ago, yes.
Q. Nine months ago. Okay.
When a collegial review happens, is there any documentation that is made concerning the collegial review?
A. Yes, there is.
Q. And what is the documentation?
A. From the physician's end, it would be in the progress notes, and from the corporate end, it would be in their records, their computer system.
Q. And when you reviewed the records for the plaintiff's case, did you see documentation of a collegial review?
A. Yes.
Q. And what documentation did you see?
A. That it took place, and that there was



an approval for a rheumatology visit, for one, and then there were some others. It must have been because he had some specialized testing, MRIs. There must have been. I just don't recall them, but they must be in there.
Q. And did you see both the corporate documentation and the progress notes with regards to the collegial review?
A. Yes.
Q. Okay. We are now on the last page, and I just wanted to come to this page of Exhibit No. 2 to see if one of these names rung a bell for the rheumatologist?
A. Yeah. Is there another part to it? These are the other people that would have been referenced in that paragraph, but the rheumatologist -- I think his name was Breen, B-r-e-e-n, if I recall correctly. Does it continue onto the next page or no?
Q. This is all I have.
A. It's not there.
Q. So it possibly does.
A. He's not added, but they don't list it here.



Q. Okay. Well, I will stop sharing my screen.
MR. LOMBARDO: Would this be a good time for maybe just a five-minute bathroom break?
MS. REED: Yes, that is fine.
MR. LOMBARDO: Thank you very much.
MS. REED: Let's go off the record.
(WHEREUPON, a recess was had.)
BY MS. REED:
Q. Dr. Funk, do you understand that you are still under oath?
A. I do.
Q. Okay. Let's continue. Are inmates allowed to request treatment from an outside physician?
A. They can request it, yes.
Q. Then what happens after they request it?
A. The physician evaluates them, if that request is appropriate or not, and then makes a decision accordingly.
Q. And if the physician agrees with that request, then does it go up to the collegial review?
A. Yes.

Q. Is there any way to bypass the collegial review?

A. Yes. There would be a way around that.

Q. How is that?

A. Well, there's a few ways. So if it was an emergency, there's no collegial review for that, or an urgent thing/matter. The physician would have the latitude to do that.

The agency medical director could authorize treatment or a procedure bypassing the collegial review, so those would be the common ways.

Q. Okay. And once a collegial review -- when it results in a yes for the physician and the physician can refer out, how do you choose who the case or the patient is referred to outside of Wexford?

A. The physician would determine which provider would be utilized, so there is a list of providers that are a specialist that see our patients, and the provider would choose which doctor should see the patient.

Q. Okay. Are there any restrictions on the physician's choice of which provider should see the



patient?

A. No.

Q. So it's completely up to the physician's discretion?

A. It's up to the physician, if he has a choice. He may not have a preference. In some cases there may not be a preference for that, and he'll just say whoever is available, but he may express a specific -- or request a specific physician to see the patient.

Q. Okay. If the inmate has a specific physician in mind, someone they saw before or someone a family recommended, would the physician consider that as well?

A. They would consider it. Generally, if a person had been seen, an effort would be made for the physician -- for the patient to return to that provider. But they can make a request, but it would not be a determination. They could not make that determination to see a specific person.

Q. Okay. Are you familiar with the approved medication list?

A. Yes.

Q. Okay. And just for the record, can you



describe what that is?

A. It's called a formulary. There are medications in specific groups that are preferred for use by the company, so it's a company formulary.

Q. And how does the company determine which medications are preferred for use?

A. By a vote from the physicians that worked for Wexford. They determine which medications should be added or removed from the formulary. There's a meeting that takes place, and physicians and other clinicians will vote on what medications should be added or removed.

Q. So is it all the physicians that work for the company, or I guess how do you select which physicians vote?

A. It would be at the direction of the corporate medical officer, and it's a select group of physicians and providers that would meet specifically for that purpose.

Q. Okay. How does Wexford and you, in particular, as a regional medical director, ensure that your physicians are adhering to the standard of care with regards to particular diseases and



diagnoses?

A. From reviewing and evaluating the decisions that they make on an ongoing basis.

Q. Are your medical files and medical decisions ever reviewed by outside physicians to determine if your physicians are keeping to the standard of care?

A. By outside physicians, you mean those that are not working for Wexford? Is that what you are saying?

Q. Correct. Yes.

A. And are you asking me if we engage physicians working to do those reviews or they are done by other parties?

Q. If Wexford engages physicians to review their employed physicians.

A. No. All of the physicians that would review others would be employed or engaged by Wexford.

Q. Okay. Are you familiar with what is referred to as a sick call?

A. Yes.

Q. And what is your understanding of what a sick call is?

A. Sick call is the term for a clinic visit, so it would be what an office visit equivalent would be in the community.

Q. In your experience, how are inmates able to request a sick call?

A. The facility will define its procedure through something called an inmate or offender handbook, which will explain to them the procedure for them to access sick call. Generally, for nonemergent matters, it entails a sick call request slip, so the offender or the inmate will fill out the information, reason for his visit, and then that is submitted to the health care unit and then processed.

Q. And how does the health care unit process that request?

A. A nurse reviews the request and then refers it to the right source, or they may conduct what is called nurse sick call, where they may address common complaints by use of nursing treatment protocols.

Q. To your knowledge, are there site specific policies and procedures with regards to processing sick calls?



A. Yes. Each site has its own process, depending on the facility makeup, its needs, so each site has its own specific policies.

Q. And in your experience, are those policies written policies?

A. They would be written, yes, and they could also be verbally communicated to the offenders, to the inmates. Generally, that is done at orientation when they arrive at the facility.

Q. If you wanted to access a written policy with regards to sick calls, is there an online database that you can go to to access it, if you need to?

A. No.

Q. How would you get ahold of that written policy?

A. By requesting it from the facility, from the health care unit administrator at the facility.

Q. Who is the health care unit administrator at Stateville?

A. Her name is Galindo. I think Lucecita -- Lucy Galindo, I believe is her first name. Last name is Galindo, G-a-l-i-n-d-o.

Q. Okay. I'm going to essentially show you a string of documents and ask you questions about them, but that is -- I'm nearing the end. Once we get through these documents, we'll be close.



MS. REED: Counsel, do you want me to continue sending the exhibits in the chat?

MR. LOMBARDO: As long as you are screen sharing them, that is fine with me. I'm not using the ones in the chat, but thanks for asking.

BY MS. REED:

Q. So I'll show you what will be marked as Exhibit No. 3. Can you see Exhibit No. 3?

A. Yes.

Q. Okay. Exhibit No. 3 is an excerpt from the Wexford guidelines, and it refers to urgent requests. Do you see that?

A. Yes.

Q. Okay. In particular, looking at the procedure, starting with A, If the site medical director or designee determines a need for urgent medical services, the site personnel submits the request outlining need for urgent request to the UM department via e-mail. The e-mail must include the word "urgent" in the subject heading to assist in facilitating a timely response to the request.



And I stopped before I read the last sentence, and I omitted a part in brackets. Other than that, did I read that accurately?

A. Yes.

Q. What is the UM department? Is that the utilization management department?

A. Correct.

Q. So when you were reviewing the file for this case, did you see e-mails marked "urgent" with regards to the plaintiff?

A. No.

Q. Did you have access to the UM department e-mails when you were preparing for this deposition today?

A. There are notes that I have, yes.

Q. What I asked is, did you have access to their e-mails with regard to the plaintiff?

A. Well, they didn't -- they are not e-mails, but they are screen shots. So their communication is written in their software, and somehow they print out their documentation. So it's not an e-mail communication. It's written in the -- their software and then they print it out, and it looks like a screen shot.

Q. So what you have -- go ahead.
A. It does not look like an e-mail, but it's their communication.
Q. When you say "their communication," do you mean the UM department's communication?
A. Correct, yes.
Q. Okay. And when you were looking at the UM department communications, did you also see communications from the site director, site medical director in that?
A. I'm sorry. Go ahead.
Q. I guess what I want to understand is, when you refer to the screen shots from the UM department, do those screen shots include both sides of the communication or just the UM's response to something?
A. It's the UM's summary of the conversation, which includes the communication from the medical director.
Q. Does it include a summary of that communication, or is the verbatim communication attached to that?
A. No, it's a summary. It is not verbatim, and there's nothing attached to it.



Q. Okay. Now I'm going to mark Exhibit No. 4. Dr. Funk, I'm going to blow this up a little bit. Can you see what I'm displaying as Exhibit No. 4?
A. Yes.
Q. Okay. Exhibit No. 4 is a grievance form from plaintiff. It's dated December 11, 2014. Does that appear accurate from your standpoint?
A. Yes, it does, but -- yeah, I remember reviewing this. And I would be surprised if I was incorrect, but I don't believe the words urgent were on the top of it, at least the one that I reviewed. I actually have that here. I can look at that and verify it, to see if I'm right or not.
Can I do that?
Q. Yes. That is fine.
A. Okay. I'm wrong. First time it happened. No, actually, that is correct. It did say "urgent" on top. The other ones did not have that written, but this is an accurate copy.
Q. Okay.
A. Thanks for letting me prove myself wrong.
Q. Of course. And so I guess, based on



what you just said, you have had a chance to review this particular grievance; is that correct?
A. Yes, yes.
Q. Do you see at the bottom of this, there is a box that is marked Emergency Review?
A. Yes.
Q. And can you tell who that signature is for that?
A. It appears to be Mr. Daniels' signature.
Q. For the emergency review.
A. Yes. Where it says, Check only if an emergency grievance.
Q. Sorry. We are on different sections. That is my fault. I am looking at the very bottom of page 1 of Exhibit 4.
A. Okay.
Q. Go ahead.
A. Could you please go up a little bit higher? There's a black box. Stop there. Yeah, actually a little bit higher. I have a black box here that says, Introducing Zoom app. Can you go up a little bit?
Q. Yes. I think the problem is when I go up a little bit, it just goes to the next page.



A. Okay. So --
Q. Let me see if I can figure that out.
A. Let me see if I can X that box out. I got it. It's gone.
Q. Okay.
A. Yeah. So the name Tarry Williams appears, and then something after that. I'm not sure what that is, initials.
Q. Do you know a Tarry Williams?
A. It's the name of a warden. It probably is him.
Q. Okay. I can go on to the next one. I'm sorry. We are going to go back to that one really quick.
We are on page 2 of Exhibit 4, and towards the bottom of this page, there's a relief requested. Do you see that?
A. Yes.
Q. Okay. And towards the end, it references his joint pains. Do you see that?
A. Yes.
Q. It also references his out of range rheumatoid factor?
A. Yes.

Q. Are those the types of complaints that you would expect to hear from somebody with rheumatoid arthritis?
A. No.
Q. Why not?
A. Because patients generally don't report their lab findings. It would be uncommon for a patient to present this way. He is interpreting his own laboratory results, and thereby may be fluid by those results, which I believe he is, has been.
Q. Now, what about the reference to the joint pain? Is that a typical complaint for someone with rheumatoid arthritis?
A. It's a part of the complaint that a patient with rheumatoid arthritis will have, but it will be characteristic -- a joint complaint is nonspecific and is usually due to things other than -- or, actually, it's rarely due to rheumatoid arthritis. It's generally due to osteoarthritis, which he has as well.
So this is not a -- to answer your question. This is not the way that a patient would present with -- he is distressed by his laboratory



finding, which is clear, but a patient who has symptoms of rheumatoid arthritis will be distressed -- will present with the symptoms of that and not like this at all.
Q. In your experience, do inmates have access to their lab test results?
A. Yes, they do. That is how he obtained it.
Q. You said, that is how he obtained them?
A. Yes, obviously he did. So they do have access, and he obtained it.
Q. Okay. I'm going to go to the next one. So I'm sharing with you Exhibit No. 5. Exhibit No. 5 is labelled, Medical Policies and Procedures, Region: Illinois. Do you see that?
A. Yes.
Q. And I believe that we received this from your counsel yesterday?
A. Yes.
Q. And I think the note with it is that you thought that it would helpful for this case; is that accurate?
A. No. It would be helpful to review it, that is what I said.



Q. Okay. Could you explain why, in your opinion, it would be helpful to review it?
A. Because you are likely to ask questions on it, so that I can respond to those.
Q. Let me ask a better question. Is there any particular section of this document that you found relevant to the plaintiff's case?
A. No. I did not produce this or request that this would be produced. It was done by counsel.
Q. Okay. And did you review these medical policies and procedures prior to this deposition today?
A. Not for this deposition. I have reviewed them in the past, but I did not have time to review these, as I just received them yesterday.
Q. Okay. And in your past review or based on your past review, is there any sections of this document that are relevant to the diagnosis of rheumatoid arthritis?
A. It may be. I have not committed it to memory and there may be, but I don't know without looking at it.
Q. Okay. I did not see any. I just wanted



to make sure I was not missing any.
A. Okay.
Q. If there's a particular one that you recall, then I just wanted to make sure that I knew about it.
A. No, I don't recall, and there may not be -- there may not be specifically for rheumatoid arthritis.
Q. Okay.
MR. LOMBARDO: I know I'm not the deponent here, but I did go through the policies and there were none about rheumatoid arthritis.
MS. REED: Okay. Thank you.
MR. LOMBARDO: We produced the orthopedic guidelines because there is mention of osteoarthritis and the treatment for that. Okay?
MS. REED: Okay. And I noticed, upon reviewing this, that the chronic pain management section was missing.
MR. LOMBARDO: We can produce that.
MS. REED: Awesome. Thank you.
BY MS. REED:
Q. Okay. Moving on. Quick question, Dr. Funk. When a grievance is filed by an inmate

Page 141

related to a medical issue, is that escalated to you at any point?

A. Generally, no.

Q. Okay. You said, Generally, no. Have there been times when it was escalated to you?

A. In isolated instances, if it involved a matter that was found to be of substance, I may be -- the incident may be referred to me, but not for most grievances. It would be rare that that would occur.

Q. So, to your knowledge, are those grievances handled by the prison facility?

A. Yes. By the staff at the facility, yes.

Q. And is someone other than you from Wexford typically involved in the grievance process, if it's medically related?

A. Yes.

Q. And who would that be?

A. The person that was involved in the matter would be interviewed. They would be -- they would participate in it, and from that -- from the investigation. The grievances that are found to have merit are discussed -- at least those are discussed at the monthly CQI meeting that occurs at

Page 142

the facility, and the regional manager and medical director at least participate in those meetings.

But if there was something that was found, for example, if it was something relating to employee conduct or something like that, it could be referred to me from the matter of grievance.

Q. You mentioned a monthly, what you called a CQI meeting?

A. Yes.

Q. And what is that?

A. Continuous quality improvement, a meeting that takes place on a monthly basis at the facility.

Q. And does someone keep the meeting minutes for those?

A. Yes.

Q. And that is a written document?

A. Yes.

Q. If you wanted to look back at prior CQI meetings for Stateville, would you have access to those meeting minutes?

A. They would be at the facility. I would have to go to the facility, but they are kept there and stored for a period of time.

Page 143

Q. Do you know how long?

A. No. They belong to the Department of Corrections, so it would be according to their policy.

Q. Now, with regards to corrective actions for physicians, is there a database where those corrective actions are stored that you know of?

A. Not a database. It would be in their employee file, if it was a written discipline or a written corrective action rather.

Q. Are the employee files digitized?

A. No. Well, whenever I see them, they are in paper format, so I don't know what the corporate office does, if they digitize them and then undigitize them, but I get paper copy or paper versions.

Q. Do you know where those paper versions are held?

A. They are somewhere in the corporate office. Maybe in the cloud, but it's not -- the human resources department is in Pittsburgh.

Q. Do you know how long those corrective actions remain in an employee's file?

A. Well, they remain permanently as long as

Page 144

the person is employed, and then for at least seven years after they leave employment, their employee file exists or is stored.

Q. Does Wexford scan copies of the patient records or progress notes?

A. On isolated and specific instances, yes, but not in general, no.

Q. We are going to look at a few progress notes and then I promise we are almost done.

A. Okay.

Q. So I'm showing you what is marked as Exhibit No. 6. Can you see Exhibit No. 6?

A. Yes.

Q. So Exhibit No. 6 is a form that is labelled Illinois Department of Corrections, Offender Outpatient Progress Notes, Stateville Correctional Center?

A. Yes.

Q. And this first page of Exhibit No. 6 does not have any information, it just has an X on it; is that right?

A. Yes.

Q. But is this the form that has been used throughout your tenure as a regional medical

director?
A. Yes.
Q. At any point during your tenure, did this form change?
A. No.
Q. Okay. And these forms are stored at the facilities after they are filled out?
A. Yes.
Q. Now I'm looking at page 2, and I just want to go over how these forms are set up. So in the left-hand column, is the date/time of the examination?
A. Correct. That's correct.
Q. Then the middle column is the Subjective/Objective Assessment column?
A. Correct.
Q. It's my understanding from reading the regulations that they first allow the inmates to describe their subjective symptoms; is that correct?
A. Yes.
Q. And then they would do an objective assessment of those symptoms; is that accurate?
A. Of their complaint, yes.



Q. And then there's an assessment after that; is that correct?
A. Correct.
Q. And in the last column for page 2 of Exhibit No. 6 is plans, and so I'm guessing that is like the follow-up based on the complaint; is that correct?
A. Yes. It's the plan. It's what course of action is to be done.
Q. Okay. So we are looking at this particular exhibit, Exhibit 6, the date and time is August -- that is either a 4 or a 9, 2012?
A. Yes. It looks to me, yes.
Q. And there is a -- looking at the third line, starting in -- we'll start with the first one. S/O is that symptoms of?
A. No, subjective and objective.
Q. Oh, subjective. Okay. Then what about the I/H in the second line?
A. It would be I/M, and it's an abbreviation for inmate.
Q. For inmate. Okay. Then there's --
A. I'm sorry. That is I/H, and that is probably in-house. It looked like an M to me, but



as I look at it closer, I think that is H and that would reasonably be in-house.
Q. Then there's an MD/SC next to that?
A. Right. That would be an abbreviation for MD sick call.
Q. Okay. And it says, For care of pain and -- I'm not sure what that next word is -- numbness?
A. Right. C/O is complaint of.
Q. Complaint of.
A. And it is numbness, pain and numbness.
Q. Then the B/L on the next line, what does that stand for?
A. Want to guess? You are doing pretty well so far.
Q. It's probably faster if you do it though.
A. Bilateral.
Q. Bilateral hands and feet?
A. Correct.
Q. And then SR is?
A. Self-reported.
Q. Is that joints?
A. Joints or joint. It might be joint, and



the next word is pain causing these symptoms.
Q. It says, And he is unable to do daily activities, is the next line?
A. Yes. That is what it appears, yes.
Q. Then there is an A that is circled. Do you see that on the next line?
A. Yes.
Q. What does that stand for?
A. A stands for assessment.
Q. So assessment, bilateral hands, feet pain and numbness?
A. Yes.
Q. Okay. Now, are these the types of complaints that you would expect to hear from somebody with rheumatoid arthritis?
A. Possibly, yes. These -- this statement paragraph here, These would not be inconsistent with the patient that had rheumatoid arthritis.
Q. Okay.
MR. LOMBARDO: I just want to jump in really quick. I should have made an objection earlier. Dr. Funk is doing -- based on foundation, just because this is not his document. He did not actually draft this. I think he's doing a good job

reading the handwriting, but I just want to make that objection to this document. Sorry for interrupting.

BY MS. REED:

Q. Okay. Going down to sort of the bottom of the last, like, five or so lines of Exhibit No. 6, page 2, it appears like they are getting complaints of joint pain off and on, stomach ache. I'm not going to try to read that. And it says that he's seeing blood off and on on tissue.

A. It says, Like when, is what it says. Stomach ache like when I had H. pylori.

Q. Okay. Reading the description in the last six lines of page 2 of Exhibit 6, does that description -- is it consistent with what you would expect to see from a patient with rheumatoid arthritis?

A. No.

Q. Okay. And what is not consistent about these six lines?

A. Because the patient is presenting with symptoms that -- for instance, stomach ache would not be suggestive of rheumatoid arthritis or expected to be present in rheumatoid arthritis.



Blood in the tissue would also not be present -- expected. Itchy sensation on urination also would not be linked in or a symptom of rheumatoid arthritis, so the presentation is not consistent at all with rheumatoid arthritis.

Q. What about the off-and-on joint pain that is referenced, is that consistent?

A. No.

Q. And why not?

A. Not in the description like that because it is -- it is a progressive usually daily pain that they have, and they would not describe it as that and limit the symptom as being joint pain. They would be more descriptive and relay the other symptoms that characterize rheumatoid arthritis.

Q. If a patient who had rheumatoid arthritis was on painkillers, for example, but inconsistent painkillers, would their pain be off and on?

A. The painkillers reduce the pain, but they don't eradicate the pain. They don't relieve it entirely. So patients who are on pain medication that have rheumatoid arthritis will still have pain and will relay that as a symptom,



but they will have lesser pain.

Q. Okay. So there's a reference to nordazepam?

A. Naprosyn.

Q. Naprosyn. What is that.

A. Naprosyn is a nonsteroidal antiinflammatory medication.

Q. And is that a medication that you would use to treat someone with rheumatoid arthritis?

A. It could be. Yes, it could be used in rheumatoid arthritis.

Q. And what -- why would a doctor use that to treat rheumatoid arthritis?

A. It would help to alleviate -- it's a nonspecific medication that is used for many different types of pain. It's not specific to rheumatoid arthritis, but it reduces pain and inflammation.

Q. And is that a prescription medication for the facility, or is that available at the commissary?

A. Each facility has its own commissary -- list of commissary items. What is on the commissary is determined by the warden. They



sometimes have nonsteroidals, and I think in the deposition, it was stated -- Mr. Daniels stated that Motrin was available. But naprosyn in a lower dose is over-the-counter. It's called Aleve, and it's possible, but I don't know if it's available from the commissary.

Q. Okay. If someone was -- I'm going to stop sharing this now. If someone was prescribed that medication and it, you know, was sold out at the commissary but generally available, would they be able to get it from the physician at the facility instead?

A. Yes.

Q. And what would they have to do -- what would an inmate have to do to get that medication from the physician?

A. The inmate would have to request, and the physician would have to agree and write the prescription for it.

Q. When physicians draft these progress notes, do they allow the patients to review them before finalizing?

A. At the time, you mean, do they allow them to --

Q. Yes.
A. No. No, they don't. They have access to the notes and can review them, but it isn't reviewed with them. They generally are -- the notes are generally in view of the patient, as the writing of it is typically done in -- with the patient present and they can see what you are writing. So they commonly do, in fact, see it, but there's no policy that says, you know, you have to -- you need to prove my note before I submit it or whatever.
Q. Okay. Are you familiar with the term "discovery responses"?
A. The legal term?
Q. Yes.
A. Somewhat.
Q. For this case were you asked to help with any discovery responses?
A. I may have been in one of the conversations. I don't recall, but I am involved in many cases. It's hard for me to keep them all straight. I may have been, but I don't recall.
Q. Okay. If a prescription is not on the approved medication list or if a particular



medication is not on the approved medication list, does the inmate still have access to it?
A. Yes.
Q. How so?
A. By the physician ordering it and filling out a non-formulary request.
Q. Can an inmate request a medication that is not on the approved medication list?
A. They can request it, yes. They can't order it, but they can certainly request it of a physician.
Q. Okay. If a physician recommends a follow-up appointment and an inmate is not able to attend for some reason, is there a protocol for making sure that the inmate is, in fact, seen for a follow-up, even if it's not on the scheduled date?
A. It depends on the reason why the appointment is not kept. Patients have a right to refuse. If they refuse, then they have refused the visit. They would not be rescheduled.
If they are not seen for an administrative purpose -- for instance, there's a lockdown or something like that, where they are not able to come because of security reasons or there's



some -- a fight or something occurring, then they would be rescheduled. They should be rescheduled.
Q. Okay.
MS. REED: Can I just have a five-minute break to review my notes?
MR. LOMBARDO: Sure.
(WHEREUPON, a recess was had.)
MS. REED: We are now back on the record.
BY MS. REED:
Q. Dr. Funk, do you understand that you are still under oath?
A. Yes, I do.
Q. Okay. Have you reviewed the assessment done by Dr. Amar Sawar?
A. Yes.
Q. And when you reviewed his assessment, was there anything in particular that stood out to you that you disagreed with?
A. Not that I disagreed with. I saw some inconsistency, I thought, in his -- in his report.
Q. What was the inconsistency?
A. The examination of his joint. In the first encounter he wrote that he had normal joints and normal strength. Then when you saw him six



weeks later, stated he had plus one swelling, I think is what he wrote.
It would be unusual for a person to have developed that in six weeks, where it had not been present the first time. That just seemed -- that struck me as just being a little unusual.
Q. Now, in Dr. Sawar's assessment, he notes seropositive rheumatoid arthritis, generalized osteoarthritis, and peripheral neuropathy. Do you recall that assessment?
A. Neuropathy. That was in one of his visits. That is not his initial impression. When he first saw the patient, his impression was different. I don't have the note in front of me, but he did not assess him to have rheumatoid arthritis on the first visit.
Q. So I think the particular date I'm looking at is June 17, 2016, so it's one of the later visits.
A. Yes.
Q. So do you disagree with that assessment then?
A. Yes, I disagree with -- yes, I do disagree with it.

Q. Okay.
A. Not his -- not all aspects of it. I do -- I agree with him having osteoarthritis and possibly peripheral neuropathy, although his EMG was normal, but it's possible to have peripheral neuropathy with a normal EMG.
But the diagnosis of rheumatoid arthritis is questionable. My opinion is that he does not meet criteria for that. I have not personally examined him, so I can't speak from my personal view. But from review of all of the information -- and, again, I have a perspective that Dr. Sawar does not, that having been able to know what the consequence was of treatment and his subsequent exams by physicians, what that has revealed.
Plus, I'm certain that he did not review every encounter since he was incarcerated, as I did. I respect him as a rheumatologist, and I'm not detracting from him, but I think if he had access to the same material that I did, his opinion would also change.
Q. Is there a benefit to actually conducting a physical exam versus just reviewing



medical records?
A. Yes.
Q. And for rheumatoid arthritis in particular, is it easier to make an objective assessment of the patient's symptoms if you are assessing him in person?
A. Yes, of course.
Q. Is there another rheumatologist that you would have referred the plaintiff to besides Dr. Sawar?
A. There are many rheumatologists. I don't know him personally, so, again, I don't think it's the difference of a person. It's the perspective that is gained from having all of the information that exists available in making an assessment. And when anyone does that and when they have limited information, then their judgment can only be -- is confined by that.
Q. So let me ask a different question. If you didn't have the benefit of all of the information that you have now, if you were in Dr. Sawar's shoes doing an assessment, would you have agreed with his assessment without -- taking out the extra knowledge that you have?



A. I may have. I mean, only seeing the patient for those brief periods of time and not being able to review records, I may have because these things that he said at the time may have led him -- I may have come to the same conclusion.
Q. Do you disagree with the prescription of methotrexate for that assessment?
A. Yes. I do now, yes.
Q. Would you -- if you credit Dr. Sawar and agree with his assessment, then would you agree with the prescription for methotrexate?
A. So in the situation that I did not have access to his other records and subsequent records, I think it would have been more reasonable to have observed him over a period of time, reexamined him because methotrexate is a -- it's a toxic drug. It functions -- the only way that one has benefit is by your immune system being depressed, and that is a very serious condition. You could potentially die from that, if you were to develop pneumonia, for example, or some other infection. So I think it would have been more reasonable to have held off and examined him again before making that decision.
Q. So when an outside referral is made, do



the physicians provide the outside physician with the medical records that were the basis of that referral?
A. They provide limited records. It would be the -- his records were probably more than 1,000 pages, and they are in paper. It would be impractical to do that, so we don't provide all of the records. In practice, it's not that it's not valuable. It is. But in practice, people rely on a patient's history in relaying their symptoms, and they don't take the time to review the records.
It would be -- it took me probably four hours to go through records, and you know from patients, when you have seen the doctor, they don't spend four hours with you.
Q. Just to clarify. You don't know whether or not Dr. Sawar read the prior medical records or which medical records he received, it's just in general practice, your assumption is it's likely he did not review them?
A. No. If they had copied the thousand pages, I would have heard about it. It would be unusual. It would not be consistent with practice to do that. It never occurs to provide the entire

record, make a copy of it and send it. So I don't know -- I was not specifically involved, but that would be an unusual and unprecedented occurrence from my 26 years of working in corrections.

Q. Let me ask, but what about with limited records that would be related to this particular referral, would it be typical for him to receive those?

A. Yes. To provide some information, like laboratory results, that likely was provided so that they would not necessarily need to be repeated, X-ray results. That is the reason why those kind of things were -- would be provided, but all of the records are relevant. And even where there are complaints not related to rheumatologic conditions are relevant records in this setting. It tells me what was bothering a patient, what level he chose to come forward with complaints, whether he had significant complaints or minor complaints. Some people just complain a lot. We have those kind of patients, and that is reflected in their medical record. So all of it is important and it should be reviewed.

Q. Okay. And in your time as the regional



medical director, what percentage of your supervisory duties have involved diagnosis of rheumatoid arthritis?

A. A very small percent, only from patients that I would directly see, and that represents a very small percent.

Q. Okay. One quick document and then I will pass it over to opposing counsel. Can you see my screen, Dr. Funk?

A. Yes.

Q. I have what is marked as Exhibit No. 7. Exhibit No. 7 is another progress note. The date on the top of the progress note is October 26, 2010, and it's referenced as a PA note. Do you see that?

A. Yes.

Q. I'll give you a chance to review this quickly and then I'll ask a few questions.

A. Okay.

Q. Now, this seems to indicate that there was a family history of rheumatoid arthritis. Is that how you read this progress note as well?

A. Yes. The patient reported to the physician assistant that there was a maternal



family history.

Q. And there's also a reference to complaints of whole body joint aches over the past several years?

A. Yes. Increasing over the past several years, is what it states.

Q. Okay. And it says, Some days he's confined to his bed. Do you see that?

A. Yes.

Q. In your experience, are those complaints consistent with someone who has rheumatoid arthritis?

A. No. It would be more consistent with other conditions.

Q. What other conditions?

A. Other rheumatologic conditions, but not typically of a patient with rheumatoid arthritis. So things like fibromyalgia would be one syndrome. Polymyalgia rheumatica, polymyositis, lupus. Those diseases would be more consistent with a whole body kind of a complaint.

Q. And if someone has a whole body complaint and a family history of rheumatoid arthritis, would it be appropriate to refer them to



a rheumatologist for further study?

A. No, I would not say so.

Q. Why not?

A. It would -- because that -- evaluation is appropriately done by primary care providers to determine what the disorder is, if there is a disorder.

Q. And when does it become appropriate to refer it out to a rheumatologist?

A. When the clinician feels they need an opinion for different reasons in the management of the patient by somebody that is -- has a specialty -- as a specialist, as a rheumatologist.

MS. REED: That is all of my -- sorry. A couple of housekeeping matters. So throughout the deposition, Dr. Funk, we have talked about various documents related to your job duties, related to the physicians, and I believe those documents are responsive to both the deposition notice, which asks for documents, and to prior discovery. And so I'm just making a note on the record for opposing counsel that we will be following up on that and pursuing those documents. It's not a question for you, Dr. Funk. It's just a note for the record.

MR. LOMBARDO: I'll just respond briefly. As stated in the e-mail, Rule 30 specifically states that document requests being made to a party in connection with the deposition notice must be accompanied by a Rule 34 request.

In this particular case, fact discovery has been closed for more than a year. Judge Cummings made an order allowing discovery to be reopened for the limited purpose of conducting today's 30(b)(6) deposition.

Defendants take the position that no further -- the document requests that were made part of the 30(b)(6) notice, that there's no obligation for us to respond to those.

MS. REED: We'll just note for the record that to the extent that there are documents that were reviewed specifically for this deposition and relied upon as well as documents that were not responsive, like I said, we'll be following up on that.

To that end, I'm going to leave the deposition open so that we can resolve any discovery dispute, and that concludes my questioning. I'll turn it over to opposing



counsel.

MR. LOMBARDO: Sure. Just briefly. All documents that Dr. Funk has been provided and reviewed in connection with this deposition have been produced already, and we would object to leaving this deposition open or a second part of this deposition.

EXAMINATION

BY MR. LOMBARDO:

Q. I'll start with just some brief follow-up questions.

Dr. Funk, you stated earlier that each IDOC correctional facility has specific guidelines for specific needs. Were you referring to a written set of guidelines that is facility specific?

A. There are both written and verbal, yes.

Q. Were the written ones you are referring to Wexford documents, or are you referring to institutional directives that are generated by the Illinois Department of Corrections?

A. I was referring to those guidelines including institutional directives but, specifically, those that are formulated by the site



or the Office of Health Services specific to the site.

Q. Are these Wexford documents or State documents?

A. No. Sorry. They are all State. I was referring to State documents.

Q. You also inferred that each employee has an employee agreement with Wexford. So in law, a contract employee has kind of a certain legal definition.

Were you saying that Wexford employees are contract employees, or could you clarify what agreements that you are referring to?

A. Okay. So I'm not sure exactly what the definition of contract employee is, but it is actually an offer letter. I take that as a contract or an agreement, so there's an agreement of employment. But I don't even know what the definition of a contract employee would be.

Q. Okay. So you are referring to an offer letter that is signed by the employee who accepts the position, when you are referring to a contract employee?

A. Yes. I was inferring that to be a



contract. I see that, in my opinion, to be a contract.

Q. The one that I was referring to before is kind of like a professional athlete who will sign a contract where they get X amount of dollars for X amount of years. That can happen outside as a professional service too, so that is a legal definition of a contract employee.

A. Okay.

Q. That is not what you were referring to, correct?

A. No.

Q. You referred a couple times to the position of the health care unit administrator. Is that a Wexford employee or an IDOC employee?

A. IDOC employee.

Q. You also referenced a continuous quality improvement meeting. Is that a meeting that is only attended by Wexford employees, or is that a joint function of both Wexford and State personnel?

A. The second, both by Wexford and State.

Q. Is it the health care unit administrator that runs that meeting?

A. Yes, or the person that she or he

designates.

Q. We talked a little bit about medication, specifically over-the-counter medications. I think you mentioned Aleve. Motrin was another one that was mentioned.

If a medicine is over-the-counter, can an inmate still get it for free if the provider deems it is clinically indicated and orders it for them?

A. Yes. So there are two things. One is that the prescription -- the medication at a higher level has to be provided by a prescription, but the provider can order it and it would be less costly for a provider to order it rather than the patient obtaining it from the commissary.

Q. Is rheumatoid arthritis a condition that can be cured?

A. No. It would not be -- it would not be cured, no.

Q. When you were discussing treatments earlier, those treatments were -- excuse me -- are intended to address the symptoms of rheumatoid arthritis, not to eradicate the disease itself; is that accurate?



A. Not quite. It is to address the symptoms. But it is also to alter the course of the illness, and that is the effects of the -- primarily on the effects of the joint but also on other organs where that -- when a patient has active disease.

Q. Based on your review of Mr. Daniels' medical records, did his complaints regarding joint pain ever require emergent medical care?

A. No.

Q. How about urgent medical care?

A. Neither. No.

Q. What about his complaints related to stomach pain, did those ever require urgent medical care?

A. No.

MS. REED: Objection, lacks foundation, vague.

BY THE WITNESS:

A. No.

BY MR. LOMBARDO:

Q. What about emergent medical care?

A. No.

MS. REED: Same objection.



BY MR. LOMBARDO:

Q. And, Dr. Funk, you did spend time, as you stated, reading these hundreds of pages of Mr. Daniels' medical records in his IDOC medical file?

A. Yes.

Q. Based on your review, do you feel that you are in a position to give an opinion whether he had an emergent or urgent medical condition?

A. Yes, I am.

MS. REED: Objection, lacks foundation.

BY MR. LOMBARDO:

Q. Dr. Funk, you gave several opinions today that are beyond the scope of a layperson. Were all of those opinions made to a degree of medical certainty?

A. Yes, I would say so.

Q. Was there anything else that you wanted to comment on or clarify any of your answers?

A. Well, my comment of what I would have is his evaluation subsequent to his release into the comment also demonstrated an inconsistent picture with him having rheumatoid arthritis. The findings of those four visits that occurred, again,



strengthened and informed my belief that he did not have rheumatoid arthritis, and his symptoms were due to other factors and that was their opinion as well.

MR. LOMBARDO: All right. I have no more questions based on that.

MS. REED: I don't have any other questions.

MR. LOMBARDO: Okay. Dr. Funk, would you like to reserve signature or waive?

THE WITNESS: I'll waive it.

MR. LOMBARDO: Excellent. Did you order the transcript?

MS. REED: I would like a copy of the transcript.

MR. LOMBARDO: We'll also take a copy, e-trans only, please.

FURTHER DEPONENT SAITH NOT.

(WHEREUPON, certain documents were marked Funk Deposition Exhibit Nos. 1 through 7, for identification.)

STATE OF ILLINOIS )
) SS:
COUNTY OF C O O K )

I, KRISTIN C. BRAJKOVICH, a Certified Shorthand Reporter of said state, do hereby certify:

That previous to the commencement of the examination of the witness, the witness was duly sworn to testify the whole truth concerning the matters herein;

That the foregoing deposition transcript was reported stenographically by me, was thereafter reduced to typewriting under my personal direction and constitutes a true record of the testimony given and the proceedings had;

That the said deposition was taken before me at the time and place specified;

That I am not a relative or employee or attorney or counsel, nor a relative or employee of such attorney or counsel for any of the parties hereto, nor interested directly or indirectly in the outcome of this action.

IN WITNESS WHEREOF, I do hereunto set my hand and affix my seal of office at Chicago, Illinois, this 28th day of March 2022.

_____
C.S.R. Certificate No. 84-3810.